



MENTAL HYGIENE

VOL. XXVIII

JULY, 1944

No 3

THE MORAL OUTLOOK OF THE ADOLESCENT IN WAR TIME

PETER A. BERTOCCI

Department of Philosophy and Psychology, Bates College, Lewiston, Maine.

I

THE effect of the war on adolescents is even more difficult to appraise in objective terms than the effect on pre-adolescents. One cannot, of course, contrast the pre-adolescent and the adolescent ages except in degree; but it is safe to say that, on the whole, the emotional and mental orientation of the child is outward. Even the child's "inward" religious and moral development finds expression in specific habit rather than in synoptic evaluation of the meaning of life itself.

We need to remind ourselves, however, that these concrete, pre-adolescent explorations and achievements in the physical and social environment create the perspective from which the adolescent evaluates his more complex world. In adolescence the capacity for abstract thought and generalization is stronger than ever before. This discriminating and synthesizing capacity enables the adolescent, in his search for meaning, to organize experience in terms of principles, laws, and ideals.

There is no need to emphasize the well-known fact that physiological and emotional changes in adolescence force new problems of adjustment into the personal and social adjustments of the "awkward age." But were these physical and emotional changes not accompanied by greater critical ability, one wonders whether the adolescent situation would

be as complex and as tension-forming as it is. For the power to think in general and conceptual terms, while making possible the better organization of experience, at the same time heightens the sense of inconsistency and conflict between experiences. Hence the increased adolescent interest in the "meaning" of life.

William Saroyan has a graphic passage in the *Human Comedy* depicting the philosophical awakening of adolescence. Homer, the fourteen-year-old messenger boy, after delivering a telegram announcing the death of a Mexican mother's son, reacts: "I feel lonely—not like I ever felt before . . . I don't know what it is, but now everything is changed . . . In two days everything is different. I'm lonely and I don't know what I'm lonely for."

Even in normal times a good part of the mental turmoil of the adolescent is caused by the inconsistencies he notes not only in his own ideals, but also in events that take place in the lives of those close to him and in the world about him. The adolescent is keen enough to see that, in some respects, the concrete personalized ideal, or hero, of his childhood has clay feet. The youth may earlier have been inclined to objectify ideals, or at least to believe that ideals, such as honesty, kindness, equality, courage, which his parents and teachers talked about so much, were dominant characteristics of the adult world of action. Now he sees the chasms that lie between idealistic generalities and the concrete facts of everyday living. Furthermore, the ideals that he accepted for himself in heroic King-Arthur or dare-to-be-a-Daniel mood are now seen to require more patience and sacrifice than he had counted on. There follow those uncertain periods approximating self-disillusionment which sometimes alternate with moral exaltation and determination.

The specific kind of development that takes place depends, of course, on the adolescent's home, school, play, and church background as well as on his intelligence; but what follows seems to describe the kind of problem that advisers must keep in mind during this period.

The moral world of the adolescent is one in which choices are exacted in a situation that not only is ambiguous or uncertain physiologically and emotionally, but also is very likely to be frustrating morally. How frequently the ado-

lescent reminds one of the child who has taken more falls than he likes and is still expected to walk, even though he hardly knows what steps to take! Yet the world exacts more from the adolescent, and he expects more of himself. Indeed, his dissatisfaction with his own inability to realize his rigid ideals is frequently projected into the world about him.

There frequently results a curious, if deceitful, sense of relief in picking apart the ethical inconsistencies of the people and institutions about him. What good excuses they make for evading social responsibilities! His moral absolutism functions both as compensation for his moral failures and as a pretext against self-blame and the bother of making changes in himself and his world.

In this situation, where the moral expectancy of the adolescent clashes with imperfect reality, the understanding and more successful adult, the sympathetic and objective father, teacher, pastor, or friend, can become a coöperative pilot, and usually does. By helping the adolescent to see that conflict and error are the necessary price men pay for the uncontrolled expression of physical and emotional energy, and by indicating concretely that real improvement is possible, even if painfully slow, the reassuring adult evokes or promotes ideals that challenge the adolescent in *the adolescent's predicament*. With his ideals now transplanted into the reality of his own past achievements and the possibilities of his particular nature and situation, the adolescent girds on the breastplate of real, rather than feigned, righteousness and sets out to rebuild self-confidence and a maturer social outlook.

II

But the war has not been kind to the situation so briefly depicted. Generalizations here are even more dangerous than in normal times; for apart from the paucity of studies thus far, we must bear in mind the fundamental fact that the impact of war is, after all, on individual personalities, each of which already represents various degrees of organization and disorganization. The war that threatens the unity of one home and one personality actually unifies and strengthens another. The considerations that follow are, therefore, those that we might keep in mind as we approach the normal

adolescent, on the way to *localizing* the specific effect the war has had in his unique situation.

Any one who has had any spontaneous contact with adolescents knows that their routines and expectancies are upset as soon as air raids, dim-outs, rationing of foods, gas, and other commodities restrict their sphere of action. They, too, "hate" war. They, too, pray for the safe return of their friends and brothers, whose letters they await with as much anxiety as do adults.

An examination of adolescent essays and conversation about the war reveals a range of feelings, from pettiness to nobility, analogous to that which pervades the life of average adults. Some do not like to get along without new clothes, silk stockings, Sunday-afternoon rides, sweets, less paper and pen points in school—and they do their stewing about it; others, quite "heroically," insist that they can "take it" and are anxious to share the sacrifices being made by brothers, friends, and mothers as long as these sacrifices mean earlier victory. These young people are proud of their victory gardens, of their after-school care of war-workers' children. With pride, too, the boys mention their added chores around the house and in the community—helping the Red Cross, staffing report centers, collecting scrap—and they are anxious to buy more defense stamps. The war has forced many adolescents to gear their vocational plans into the war effort, even at the sacrifice of a college education.

These facts are a commonplace to those who listen to adolescent comments on the war. The following are typical:

One junior-high-school girl says: "The war has left a big dent in my life. My oldest brother has left for the Army Air Corps. Another brother leaves in July. My spending money has been cut down, with my oldest brother leaving. Now, instead of having fun after school, I take care of children for war workers from 4 p.m. to 11 p.m. When you want new clothes, last year's things are cleaned and made to do another year. . . . I really don't mind giving all these things up because it means my brothers and friends will all be home sooner. By taking care of these babies, it leaves two more mothers available for war work."

A boy comically remarks: "At the movies we go to the candy counter; and when we reach it, we find nothing but peanuts."

Another philosopher states: "A war like this teaches us many things. We learn to be more saving of materials, such as paper, clothing, metals, and also fuel. We learn, too, about the foreign countries where our

soldiers and marines are fighting. . . . Perhaps we could imagine a life with a ruler like Hitler, and then we would be prepared to do our utmost to win this war."

Another junior-high-school girl: "The war means sacrifice and a growing understanding of life to me. Understanding and supplying the wants and needs of these men who are fighting for the greatest ideals in the world is often sacrifice. When I hear of the shattered lives and countries of Europe and Asia, I am getting a better understanding of life and its sorrow and hardship, as well as the happiness and joy I already know. I realize that the war has awakened America; but the American people lack the faith and spirit of the Russians, Greeks, and other countrymen who are fighting so hard for their freedom which in many cases is already lost. I hope there will never be a conquered America, a place where people could not write and say the things they wanted to."

A high-school boy comments: "Knowing that I am going to war, and knowing that I have enlisted in a tough and dangerous branch of the service, I like to get a little fun that can be still had before I go. . . . Many people think there will be happiness after the war; I hope so, but I don't see how there can be, with all those that will never come back and with all those that come back crippled. There will be no fun for those who love them. So I figure the fun is before you go; and if there's more fun when you come back, so much the better."

III

It is clear, then, that the feeling of greater urgency that envelops the life of a nation at war is not a favorable factor in the conscious-unconscious struggle for status, significance, or meaning. The adolescent, who wants to know where he stands, what his life can mean and does mean to others, is not likely to be aided by the war-time sifting of values and shifting of emphases. No wonder some of them are finding it difficult to concentrate on a controlling purpose!

For one thing, parents and teachers are themselves having a hard time to readjust their lives, not only to new schedules, but to new ways of thinking about things in the home, school, church, work-a-day world, and nation. Their own lives are being uprooted and they themselves tossed about by mixed feelings and loyalties. Teachers and guides, especially men, are fewer and overburdened.

Thus, the adolescent is left in his own somewhat topsy-turvy home-school-church-world situation to work out many adjustments that are makeshifts "for the duration." The predicament is, of course, all the more shocking for the millions of adolescents in war-torn countries.

Thus, almost every immediate objective and every kind of guidance that the adolescent might count on in peace time is jeopardized. This in itself is adequate basis for nervousness and anxiety, let alone the devil-may-care attitude toward life. Conceivably the adolescent might learn to take these things, provided he could understand their necessity or desirability. But here are adults, in an adult world, seemingly breaking every rule by which they had sworn! Death, sudden, merciless, and remorseless, for civilian as well as soldier, becomes the objective of every hour—death to the enemy for whom we were supposed to pray! Catch-as-catch-can, the sneak-play, double-talk making the worse appear the better reason, profiting by the mistakes of others, hoarding, black markets—these deadly sins now seem to have become the very means of survival! Riotous living is frequently tolerated as if it had to be the inevitable counterpart of military discipline.

IV

Can the adolescent, thus beset, be given constructive guidance? Can his search for meaning be directed through such moral chaos? Have we any other answers for him besides the slogan? In this situation fraught with emotional and intellectual uncertainty, the adolescent is certainly susceptible to suggestion, and he can be herded into a youth movement where he need no longer share personal responsibility for his deeds and action. He can be kept busy at some job (we have a way of wanting them to do something, especially when we don't know what!) in the hope of getting his mind off himself—which frequently means simply repressing some of the most challenging doubts and opportunities for growth in his life.

Let this kind of thing continue and later he'll be wondering himself why he can't quite coöperate whole-heartedly with anything, why he can't "settle down," or seem to know what he wants. He can be herded to the factory or the farm to do his bit, either by blind loyalty to the country that nourished him or by blind hatred for the enemy, or by both. But can we be satisfied with these unhealthy substitutes even as makeshifts?

We must, without hedging, meet the needs of the adoles-

cents who have these intellectual and moral problems. It will not do to suggest that only a few have them. Let us at least be clear on one point: If we allow the adolescent who does have the moral problem to decide that there are no reasonable solutions to his questions, we are encouraging the very attitude that so many people cry-babied about at the beginning of the war when they wailed: "Young people to-day have no moral convictions, no belief in right and wrong. They refuse to make moral distinctions between white, gray, and black!"

But these young people were the product of an age when conventionality decided the course of action, when the mores of a group were the fundamental things to be considered in deciding a question of rightness and wrongness. Who, then, could logically blame them for saying that they would hesitate before they risked their lives for conventions that were not necessarily right, but merely at odds with the conventions of the Germans? They were blamed, we recall, for being selfish and disloyal and were contrasted with the loyal and devoted members of Fascistic youth movements. Perhaps the only real difference psychologically was that German and Italian young people had suffocated their moral doubts and compensated by vicious loyalty to a new order which exalted the principle that there was no right and wrong except as they, the Fascists, made it so.

We have now gotten our young people to coöperate with the war effort. The Pearl Harbor "stab-in-the-back" unified them and the nation against the attacker; the departure of brothers and sisters, to say nothing of fathers and mothers, has brought out elemental loyalties and sentiments. They know what they are against, what they don't want. Yet, as the war goes on, as the destruction and terror and sacrifice bear in upon their lives through those they love, the moral problems will make themselves felt again; and morale, let us remember, is in the last analysis a matter of morals, a matter of deciding what is worth living and dying for.

V

I shall, therefore, devote the remainder of this essay to a mere outline of an approach to the concrete moral and philosophical problems felt by some adolescents. I am aware

that there is nothing particularly new in these suggestions and that much needs to be added to them; but if they serve to illustrate a basic approach, my purpose will have been realized.

Our main objective is to help adolescents see for themselves what the causes of many human catastrophes are, to create in them a sympathetic awareness of the tasks involved in improving society, along with a determination to face the good and evil around them with a creative will. In order to do this, we must understand the specific logic and psychology that lie behind some of the concrete complaints of the absolutistic adolescent who is confused and disturbed by the calamities of war.

First, we had better admit the neglect and shortsightedness that contributed to the final outbreak of the war. We adults might have done more to make a Hitler impossible if we had decided to sacrifice some economic security and some political prestige in order to inspire greater confidence in our good will in the peoples of Italy, Germany, and Japan, especially at the time when they needed to feel that confidence in us, lacking which they turned to their dictators.

This confession, however, should serve to make clear what happens in the social world when the strong turn deaf ears to the cries of the insecure. Our adolescents need to see what we are learning—that when men do have peace, they have it because there remains, despite human selfishness, a saving portion of concern for less fortunate neighbors. Are we not living illustrations of the moral fact that when people try to live unto themselves and accept only convenient responsibilities, disaster follows both for the "haves" and for the "have-nots"?

We would not have to follow this train of thought far before we confronted another real obstacle to effective living. The natural adolescent question, "Why should *we* suffer for the mistakes of others?" indicates initial misunderstanding of the game of life. The adolescent must see that a mature person does not just demand blessings, even goodness, from others as if it were a birthright. He learns to work with others to make the next ten yards. In some plays he, the tackle, must bear some of the punishment that comes when the guard has misplayed or underplayed his position.

We can't have the best things in life, courage, forgiveness, handed to us for the asking; we work for them and enjoy creating them. We, his elders, have been waiting a long time for him to grow up and help put the ball over the line.

The adolescent, in other words, must be saved from his own dogmatic absolutism, from his tendency to see things in blacks and whites. This absolutism sometimes gives the adolescent an excuse for not doing his best. Evil is so rampant, people are so imperfect, that nothing can be done, so why should he expect much of himself? At the same time the adolescent may actually be feeling so guilty and so disillusioned about himself, owing to unrealistically high ideals, that it is almost a comfort to know that others have had little moral success. He may enjoy cynically criticizing his folks, the school, and the church; but his "righteous" indignation gives him away to the discerning adult. It is so hard for him to give up the ideals pictured so concretely in his earlier heroes and heroines, especially since he does not know exactly what to do once he has found his specific pattern of life unadjusted to his new world.

Here, in this process of moral reconstruction, as he tries to replace hero-worship by critical ideals based on his own abilities and his own present place in the world situation, we can help him most. If he realizes that the evil around him is really proof that idealism is needed, he can now see what happens when ideals try to do too much at once or do not come as challenges out of life itself. Assuming that good will, honesty, justice, equity, and courage are things the world sorely needs, can't he humbly enlist his best effort in his corner of the world to develop these qualities in himself and others?

It is in this everyday light, it seems to me, that the adolescent should formulate his plans for the future as far as possible. He can work *now* to be the kind of man America wants to father the children for whom his brothers and sisters are now sacrificing. If he can learn now to be a good sport, to think of the needs of others, he is sowing the seeds from which a good family will be harvested. Through his vocation and his family, he makes an essential contribution to the community. To these, however, he brings the thinking ability and the fund of knowledge, techniques, and attitudes

he develops at school. He may not be a genius, but he can learn *now* that most human problems have a history that roots in the economic and political doings of man, on the one hand, and in ethical and religious actions and aspirations on the other. Right *now* he can take active part in institutions like the church, which are doing what imperfect, but aspiring human beings can do to increase the goodness and stability of the community in which they live.

These suggestions are made in the conviction that the adolescent whom such considerations touch soon comes *to see himself and his struggle in a new perspective*. He is no longer "alone"; he expects himself now to be a thinking, growing member in the human enterprise which looks to an increased stability and good will as the dependable basis for the development of the individual. He now becomes the idealist with a cross to bear, fully expecting difficulty and disappointment on the way to the achievement of his goal. The important thing about life, he now sees, is the objective and the struggle to the objective. Sacrifice and suffering, he realizes, are present in all life; human beings have to decide what suffering and what goals are worth while.

The adolescent who can see the ties between his own efforts on the home front and those of his allies at the war front finds a new source of inspiration in "belonging" to the war effort. Here, indeed, is the source of democratic adolescent morale. His disappointment, becoming universalized, loses its self-centered qualities and releases his idealistic sentiments, with a more determined and sober willingness to suffer. For he now sees himself as a responsible participant in the creation of a social ideal which needs fresh minds and a new spirit; he experiences the blessedness of giving what is needed and not merely expecting what he wants—which was the essential pre-adolescent outlook.

VI

So far we have emphasized the necessity of reinterpreting the war situation so that the adolescent can more clearly see the part that adults play in it and the part that he himself can play. We have not gone into detail about the specific war-time needs that the adolescent can help fulfill

in his community and nation, for these are better outlined elsewhere. We want rather to emphasize that the *moral value* of what the adolescent does depends upon the interpretation he puts upon his actions. It makes all the difference in the world, for example, whether he helps in the scrap drive because he sees that this is one of the ways in which he can satisfy a real need in the community effort, or whether he does it because the gang is doing it, or in the mere hope to get the war over as soon as possible. Each reason reflects a certain general attitude toward life. His "philosophy" may include a positive willingness to help wherever human beings are in need, or "coöperation" merely from social pressure, or the desire to return as soon as possible to pre-war comfort. His action is an expression of a conclusion about the meaning of life and perhaps at the same time a formative factor in his groping for a life plan.

VII

We have not, in other words, helped the adolescent to develop a long-run morale by just getting him to do something, to feel needed or important; the motive behind his actions in relation to a developing philosophy of life is the important objective. The intellectually maturing adolescent wants and needs more than the easing of conflict through doing something; he wants and needs a conception of life in which he can evaluate his "doings."

We have already hinted at a social outlook that finds a place for one's own abilities and needs in coördination with those of others. In what other philosophy besides that of democracy is such emphasis placed on patience with others' opinions and actions, on intellectual, social, and economic sportsmanship, on responsibility not only for self, but for the needs of others? Here is an ideal for him to measure his own life by and for him to grow by!

Fascistic young people have placed their problems once for all in the hands of their Fuehrer, who has assumed their responsibilities at the price of their implicit obedience. Their bothersome doubts and uncertainties have been solved by temporary forgetfulness and fanatical trust. They have referred them to the idolized Fuehrer. We can help our

young people see the world they can build by assuming responsibility for their own freedom of thought and action and by being anxious to coöperate with the freedom of thought and action of others. This seems the harder way, but it takes its grip in the desire of adolescents to live and let live.

Yet not even a democratic social outlook is going to appease all adolescent emotional and intellectual frustration. The adolescent has heard about wars in the past, and he has heard about the Kingdom of the God of Love, Who cares for men and what they do. If a good God made men, why did He allow them to be so selfish? If He cares about men, why does He allow the war system as one of the possibilities open to them?

The adolescent has his own version of the age-old problem of evil. The harder life becomes for him and the less meaning he sees in suffering and disaster, the more he, too, asks: "If God is good, can He be omnipotent? If He is omnipotent, can He be good?" From the point of view of mental health, what more empowering conviction can there be than the critical belief that man's struggle for goodness is sponsored and supported by the Architect and Pilot of the universe?

At this point we must remind ourselves that the adolescent has been brought up in a spiritual climate that at its best has been invigorated by that world view. His exposure to Christianity directly in the home and the church, and indirectly in the school and the cultural atmosphere, has probably left him with a certain expectancy; and, even if he cannot define it in so many words, he is aware of a belief in a beneficent Power in the world. The more conscious he has been of this belief, the less he has dissociated its implications from his actual personal and social attitudes and sentiments. In any case, the war is likely to shock that belief into criticism.

Thus, the adolescent who sees the merciless persecutions of specific races or groups of men, the adolescent who sees an equivalent hatred raging in some of his friends and respected adults, the adolescent who reflects at all on the suffering and tragedy that have overtaken both good and bad men within his own and the enemy countries—that adolescent

may well wonder whether God has taken a holiday. As one high-school senior put it in the usual black-and-white terms, "If there is a God, why is Hitler still living?"

Along with this tendency to religious disillusionment, one frequently finds less optimism about human nature. To quote one adolescent of sixteen, "I think that people are more selfish than they were; I have my opinion on the stocking up of goods before the rationing." Fortunately, we cannot generalize this statement. While the war makes life all the more worth living for some adolescents (a rather reflective and well-balanced seventeen-year-old said, "I feel it is more worth living because I would like to have a part in building a better peace."), we cannot overlook those who find their faith in the goodness of men and in the goodness of the world process shaken by the events of war.

Once more, the approach involves exposure to a broader horizon and a reconstruction based on more of the facts than the adolescent, in his disappointment, is seeing. This is no place to attempt to solve the problem of evil, but we are culturally and philosophically bankrupt indeed if we cannot make our young men and women aware of some of the approaches to the solution of this problem. We can at least keep them from overlooking the problem of goodness! Too long have we hesitated to wade into this kind of problem when we have met it—as if we could give life adequate meaning on a convenient sidetrack of forgetfulness and ignorance. Unless we are going to leave adolescent minds suggestible to poorer solutions, we will do well to take them as far as we can along the lines already traveled by man, and leave the problem where man has left it, partially solved and at any rate properly localized. The adolescent whose intellectual doubt has been honored is willing to take his chance with a philosophy that is incomplete because life and the world process are incomplete.

To repeat, instead of handing the adolescent mind ready-made dogmas, we can help him to see how and why evil arises. We can ask him in fairness to the facts to remember that the physical universe in which men live is—on the whole, at least—conducive to better human existence than we have achieved so far. And we can show him that were

men to coöperate with one another in this bounteous universe, instead of trying to "hog it all," the great majority of evils could be eliminated.

What he must realize is that he probably has been wrong in supposing that God would hand man coöperative blessedness on a platter, as if it were the sunshine and the rain and the good earth with its treasures. Perhaps God wanted men to be "like God" and to help create goodness of character, graciousness of action and thought out of the possibilities of their own human nature, which is plastic enough for both good and evil. Is it not all-important for the adolescent to see that the highest goodness is that which he creates voluntarily through self-discipline, that the essence of a really good God is that, like a really good parent, He allows His children to make their choices and then suffers with them the consequences of their actions?

The war itself represents what men have done with their own natures and with the world; both could have been used, man willing, to promote growth and peace. So long as the adolescent thinks that he is entitled to a better world than that of his parents or of God, he is in the throes of the fundamental human maladjustment—the thought and expectation that there can be lasting good which does not involve deserving effort on his part.

There are, of course, problems that come up that cannot be fittingly solved, such as the great amount of evil for which no man can be blamed through misuse of free will. Every philosophy has that problem; some philosophers are suggesting that the loving Father is not completely omnipotent, that there are problems He has Himself not completely solved. The least we can do is to show the adolescent why some of his problems, including the persistent problems of humanity, do not have complete theoretical solutions.

But—and this is my point—we can leave the adolescent with the intellectual frustration partly justified and partly classified. He can now walk to and fro in his thoughts, and he can see alternatives more clearly. He can at least understand the dynamic and the spiritual atmosphere in the world in which he has grown; he can better justify his own faith in the presence of opposing philosophies about man and God.

He will not be able to conclude that God is all on the side

of his country in the war, but he can try to judge the spiritual issues and mixtures of motives underlying the efforts of his own country. And his own relation to the fundamental issues of life in war and peace, his own sense of values, will have been put on a more realistic footing. What is more, he may develop a sense of the importance of his own choices and sacrifices in a world in which men must lock arms and work together for the kind of goodness God seems to favor. If he cannot be promised success, he can be promised a worthwhile struggle, with great stakes and strong odds.

OFFICERS AND THEIR RELATION TO A MENTAL-HYGIENE PROGRAM FOR TRAINEES

LT. COL. R. ROBERT COHEN, M.C., A.U.S.

*Psychiatrist, Army Service Forces Training Center,
Aberdeen Proving Ground, Maryland*

NO MENTAL-HYGIENE program for trainees can be successful unless the people entrusted with the training understand that the mental contentment of the trainee is a key factor to be considered. This important goal can result only from good leadership; it, in turn, then results in good discipline and morale.

For that reason, the material that follows was presented, in the form of explanatory talks, to the officers and non-commissioned cadres of all companies used in an experimental program for preventive psychiatry at Army Service Forces Training Center, Aberdeen Proving Ground, Maryland.

I. MILITARY MORALE AND MENTAL HYGIENE

Morale is an intangible quality, but—like electricity, which likewise can't be seen—it is powerful. "Morale is to the mind what condition is to the athlete's body. Good morale is good conditioning of the inner man. It is the state of will in which you can get the most from human machinery, deliver blows with the greatest effect, take blows with the least depression, and hold out for the longest time. It is both fighting power and staying power, and strength to resist the mental infiltration which fear, discouragement and fatigue bring with them. It is the perpetual ability to come back."¹

To inculcate proper military morale during war time, training must accord with the ideals of conduct and society prevalent in the national civil life of citizen soldiers. To apply

¹ William Ernest Hoeking, as quoted in "Morale in Naval Hospitals," by Lieutenant Commander Joel T. Boone. *The Military Surgeon*, Vol. 47, pp. 268-94, September, 1920.

indoctrination in any other way would be useless. For instance, it would be impossible for us to attempt morale-building on the same premises as the Japanese. For them, their morale factors are sound, because they blend with Japanese national beliefs. The Japanese soldier's morale is based on his unwavering belief in the divine origin of his emperor. In Japan, military conscription has been universal and honorable for the past 2,600 years. Devotion to duty, bravery, and loyalty stem from a national worship, Shintoism, the reverence for ancestors and for emperor. To the Japanese, to bring dishonor on one's ancestors is unthinkable. It is likewise dishonorable to "lose face"—to lose one's prestige in the eyes of others. A Japanese soldier who runs from the enemy loses face—the worst possible calamity. For him, suicide is much more honorable than surrender. He performs suicidal tasks with fanatical indifference to danger because to him this life means little; the next life, in which he will join his ancestors in an honorable and glorious manner, is the all-important thing. He has been taught from early childhood that only the Japanese soldier is willing to give up his life for his country—that Japan never has been nor ever can be defeated!¹

Presenting any such creed to the American citizen soldier could result only in ridicule. He has faith in the realities of life, in the principle of fair play. He has boxed, and knows that the fellow who "keeps his head" can always knock out the punch-drunk mystic who abandons all caution. He knows the lesson taught by American history—that a well-aimed bullet very adequately took care of the fanatical Moro. He has been reared in a generation of American pacifism in which the very mention of war was condemned. He has been educated from childhood in the belief that his liberties, his freedoms of speech, of the press, and of private opinion are precious rights of his citizenship. He has been brought up in a society that expects him to submit to authority only when he recognizes the need for obedience. With the American citizen soldier, therefore, officers and noncoms must base morale appeal on this particular background and on this

¹ See "Notes on the Japanese Army: Psychology of the Japanese Soldier." Information Bulletin No. 2, GHQ, U. S. Army, Army War College, Washington, D. C., December 19, 1941.

characteristic psychology. To assure mental contentment for the American, we must tell him not only *how*, but *why* we expect certain things of him. Moreover, we must give our explicit, confidential explanation in the warm, fraternal manner that he knows.

Accustomed to such civilian freedom of environment as is not accorded any citizen in any other country in the world, it is to be expected that when the American citizen soldier is suddenly transplanted from his unrestricted civilian surroundings to the necessarily restricted environment of the army, his mental adjustment will undergo temporary strain. Bewildered and emotionally upset, he easily becomes a victim of mental maladjustment unless he is given some psychologic preparation for this abrupt change. It is only natural for him unconsciously to resent being deprived of his civilian liberties and privileges, of his close association with family and friends, of his job or profession. Grouped with men of varying economic and intellectual levels, he is thrust into military regulations foreign to his civilian education. Consequently, without guidance, he may develop the mistaken conception that the army is a cold, impersonal master which has no interest in him or his individual problem. And this opinion, thus formulated in his mind, lays the foundation for mental upset.

Anxiety, with its fears and conflicts, is thereby engendered. The soldier cannot get any training when he has become the subject of bodily reactions to worry. His unguided attempts to attain freedom from mental fears and conflicts only cause his nervous system to run riot. Every conceivable kind of physical symptom of circulation and digestion occurs. Every new undertaking from then on is met with lack of confidence and fear; and every new situation brings him closer to a true neurotic state.

With this kind of mental groundwork, good morale is either impossible or, at best, is poorly attained. Possibly such a soldier, if given sufficient time at a training center, would make a belated mental adjustment, after much time lost by needless hospitalizations and additional training. Enough time for complete unaided adaptation is not available, however, and a great many partially adjusted men are shipped to

combat areas, where they may break down—victims of mental uncertainty and poor morale.

The lesson to be remembered by every officer and noncom, then, is that the primary and most important goal of morale is the mental contentment and well-being of the soldier. This does not mean pampering him. The American soldier does not want to be pampered! It means only giving him enough personal attention to insure an increase in his military efficiency.

To secure this kind of mental contentment, prophylactic mental-hygiene measures should be applied to every new civilian soldier during his first contact with the army. Mental hygiene is the science that deals with the development of healthy mental and emotional reactions and habits. Such a mental-hygiene program has been worked out at the Army Service Forces Training Center to help the officer bring about rapid military adjustment for his men.

Through a series of talks, every man is made to realize that the army is an understanding organization which recognizes his problems and is eager for his adjustment; that the army knows both his immediate problems and the adjustments that will be required of him in the future. It is pointed out to him that individual sacrifice is essential to the attainment of our national objectives; that regimentation is necessary for discipline and teamwork. By being helped to bring out into the open any smoldering resentments that he may have, by being familiarized with the normal and the abnormal methods of adjustment, by being warned that worry and fear may result from anxiety about the unknown, and instructed as to how the body produces physical symptoms in response to states of mind, he will be better prepared for his new situations.

That this method helps men attain mental contentment has been shown through controlled experiments on new trainees.¹ By the use of this method, it was found that sick calls and hospitalization days for nervous, emotional, and fancied complaints were cut down. From 122 to 531 man hours were added to the training time of a single company in any four-week basic training period. AWOL's were materially cut

¹ See "Mental Hygiene for the Trainee," by Major R. Robert Cohen. *American Journal of Psychiatry*, Vol. 100, pp. 62-71, July, 1943.

down. Efficiency of training was increased. Improved grades in tests on training resulted. Greater interest and eagerness of the men in their training were indicated. The Sunday sick-call rate went up, and the total sick-call rate for all causes went down. Men did not report on sick call with inconsequential complaints. They did not *wish* to waste training time; they saved their *legitimate* sick calls for their free time on Sundays. A favorable mental attitude of the men was shown. Responses to the questions: "What did you think of the talks? Have they been of any personal benefit to you?" brought forth such representative quotations as:

- "They opened a man's mind and enabled him to diagnose many of his problems."
- "If I could remember them, I believe they would help me all my life."
- "Have helped my spirits and made me realize what I'm fighting for."
- "Have encouraged me to do my best in my training to learn everything I can."
- "Helped me from becoming homesick."
- "Several fellows who had kept pretty much to themselves are now openly expressing themselves."
- "Brought men and officers closer together."
- "Straightened out my personal loneliness."
- "I was straightened out on some of my reactions which I could not account for."
- "Some of the others are less fearful and anxious and seem to have become better adjusted since hearing the talks."
- "Helped me to relieve a worry which I was foolishly allowing to gain control over my working senses."
- "Made some men feel they were more than a number."

Specifically, this mental-hygiene method consists of four talks¹ given on the first four consecutive days of the soldier's basic training period. All deal with factors in adjustment to the army. They ease the transition from civilian life to army life. They emphasize receptivity to training throughout. All follow the general outline: *What* each factor is, *why* is it present, the *normal* and the *abnormal* reactions to it, and specific advice as to *what to do* to secure the normal and prevent the abnormal reaction.

The first talk, *Normal Civilian Resentments*, shows how the method of selecting men for service is part of their American heritage. It enumerates the normal civilian resent-

¹ See "Factors in Adjustment to Army Life," by Lieutenant Colonel R. Robert Cohen. *War Medicine*, Vol. 5, pp. 83-91, February, 1944.

ments of every trainee when he enters the army. It shows why this group of resentments, homesickness, is present; how it is normally adjusted to by toughness and humor; what occurs when it is reacted to in an abnormal manner; and how to prevent and to overcome the abnormal reactions.

The second talk, *Regimentation*, defines that word of hateful connotations to the American ear, in terms of coöperative military training, as necessary for teamwork. It enumerates the resentments due to regimentation. It points out that "griping" is a normal accompaniment of this new type of training and is the healthy mechanism by which regimentation resentments are overcome. It describes also the abnormal attitude, its effects on bodily function, and how it can be overcome.

The third talk, *Fear*, defines that emotion, shows its universality, and describes its normal physical manifestations. It gives a motive for willingness to expose one's self to danger. It describes the normal behavior mechanisms for eliminating a fear situation—the substitution mechanism of a plan of attack (courage), and the conversion mechanism of changing fear to rage. And it describes the abnormal fear reaction, playing sick, with ways to prevent and overcome it.

The fourth talk, *Military Mental Hygiene*, summarizes all the factors in the transition from civilian life to army life. It cites again the three main factors in adjustment—civilian resentments, regimentation, fear. It emphasizes the normal mechanisms for adjusting to these factors, and describes the abnormal reactions to these factors and how to overcome them.

To the extent that it lays the foundation for the mental contentment of his men, this mental-hygiene program will work for the officer. It gives him an understanding of the men's psychological reactions. It shows him how a mal-adjusted mind can bring on actual body complaints. It tells him what mechanisms of advice he can recommend for overcoming sick complaints due to mental states. The follow-up, however, will be in his hands. He must be the one to give guidance to his soldiers. He must establish a man-to-man relationship of friendliness with them. He must project himself into the situations and feelings of his men. He

must make them feel that to him their individual problems are important, that their troubles are always his concern. His subordinate officers and noncoms must be made to feel as he does and must know that he is never too busy to see his men and advise them.

If these rules are applied with a firmness that does not arouse antipathy and with an understanding that does not smack of sympathy, he will win the respect and loyalty of his men. They will exemplify good morale and self-discipline, and he will have approached true leadership. His formula for victory will be sound, for he will have based his leadership and their discipline on the morale of the individual soldier. He will then have carried out the fundamental truth known by all true military leaders—that man himself is the only basic weapon of war that is constant and unchanging, and that on his mind and spirit, on his morale, depends the victorious outcome of battles.

II. MILITARY LEADERSHIP

It is generally agreed that the most important attribute of a good officer is leadership, the ability to lead men. Webster defines leadership as the ability to guide or conduct, and thus to lead in action, thought, and opinion.

In civilian life, the man who is best in his field is classed as a leader because the rest of that field is guided by his opinions. The successful business man is classed as a leader because of his influence over his few business associates. The foreman is classed as a leader because of authority over his small group. The administrator is classed as a leader because of his outstanding ability to manage and organize.¹

In military life, however, especially during war time, these qualities alone are not enough to equip an officer for true military leadership. Nor does even his authority due to rank, nor his tactical ability to direct operations, nor his managerial ability to carry out staff functions, give the complete answer. The real military leader must have all of these qualities—and more. He must, in addition, have the ability to influence large masses of men to act together to

¹ See *Psychology and Leadership*, by Captain J. H. Burns. Fort Leavenworth, Kansas: Command and General Staff Press, 1934.

carry out his plan. Like his rare counterpart in civilian life, as exemplified by a statesman of the caliber of President Roosevelt, he must be able to arouse, control, mold, and direct the *minds* of men to attain his desired end. He leads by his ability to sway the *minds* of large groups. He need not be the most astute strategist, nor bear the highest rank, nor be the finest technician, nor be a "driver" of men; for even in defeat his power over his men is not completely lost.

"How, then, does he acquire this magnetic quality, this profound power over the will of his men that will make them show the greatest moral and physical courage, withstand the toughest hardships and privations, endure the heaviest fatigue, enable them in the face of all adverse circumstances to force their will on the enemy"?¹—and all this despite the fact that soldiers are not robots, but humans who prefer living to dying? The answer lies in psychology, in an emotional approach. Handling men is an art that comprises more than just "the know how and the authority" to give orders. Leadership is not inherent; it is acquired and cultivated by following definite principles.

The true military leader, exemplified by General MacArthur, realizes that man is the basic weapon of war; that unlike tactics, which may change completely because of new weapons or techniques, man is constant and unmodified by time. But he knows, too, that even though man is a thinking creature, his conduct is not regulated by rational thought, but rather by the driving power of his instincts and emotions.

The military leader understands why our military methods for developing armies are sound—how they are all based on control of the individual in units because of the human tendency to form groups. He capitalizes on this tendency, which technically is the herd instinct, the urge to be one of a group and to conform to the standards of that group in conduct and in opinion. A person in a group acts differently from the way that he acts as an individual. He merges with the crowd and loses his identity. Stimulated by the closeness of his fellow men, by the common national background of all, by eating together, sleeping together, working together, being

¹ See "Moulding Men for Battle," by Major General H. E. Ely. *Coast Artillery Journal*, Vol. 82, September-October, 1939.

uniformed alike, the individual loses his personal opinion and comes to think like his group. He soon becomes sensitive to the voice of the group; his conduct is in line with that of the group; he manifests the same passions as the group; he becomes dependent on the group's recognition of him as one of its members; he desires to retain the good opinion of his fellows and undergoes mental anguish if he is alone, excluded from the group.

Ordinarily, in peace time, when soldiers are enlisted and there is plenty of time to change personality to the required military pattern, stressing only rules and regulations with the reasons for them will bring the desired control in the requisite training time. In war time, however, when suggestible, excitable men are inducted from their familiar civilian life to unfamiliar army life, they bring with them their resentments, their tangled emotions, their prejudices, and their personality traits. There is no time to mold character gradually into the military pattern. Ruthless attempts only arouse fear, resistance, and hate. Military rules and regulations alone are not enough. All the new soldier's eagerness and willingness to learn can be turned into cynicism and suspicion if he is subjected initially, without explanation, to training that appears to him to have no other object than to harass him with petty restraints.

The true leader, aware of these things, treats his men psychologically. To overcome the abhorrence of warfare, the feeling of guilt over killing, he mobilizes all the aggressive urges of his men by appealing to their sense of duty, their patriotism, the code of the soldier; to balance the instinct of self-preservation, the fear for personal safety, he substitutes an even greater fear, the fear of disgrace for conduct unbecoming an American soldier. He does these things by giving his men an overpowering motive, an overwhelming faith in their cause that appeals to the emotions. "We shall win or we shall die!" said General MacArthur. "We are American soldiers, and by the Grace of God, we will fight the enemy until he is vanquished." He might also have said, "We are fighting to preserve decency. And what is decency? It is the right to live and die without fear; the

right to live among friends and family; the right to die in peace amid quiet tears, hoping to find a place beside God. This is worth fighting for; this is worth killing for; so that good people may keep their world a decent place in which to live and die.”¹

The leader teaches discipline, too—discipline *not* as blind obedience, but as a part of a deeper quality, morale. He knows that the primary purpose of morale is to secure the mental contentment and well-being of the soldier; that this does not mean to pamper, but only to give the humane attention necessary to increase military efficiency. He explains to his men their relationship to the army, with the *whys* and *wherefores* of their adjustment to military training completely and clearly outlined. He is understanding and patient; he talks to his men about their resentments, their prejudices, and their traits, and advises them in a fraternal, human manner. He gives them respect and warm approval so that they in turn may develop self-respect and mutual confidence.

His teaching and guidance, moreover, are in accord with the mentality of his citizen soldiers. He knows that “the American of to-day is as well educated as his officers; he has an equal endowment of patriotism, of understanding of the cause for which he serves, of devotion to duty and country. He is inferior only in military knowledge, and this he seeks to remedy with an eagerness that needs no driving. He obeys willingly and intelligently when he knows the need for obedience.”²

After thus acquiring his men’s confidence, the true leader continues to merit it. He shows them, by his knowledge of every situation, that “he knows his stuff”; he does difficult jobs along with them. He never assigns an impossible task, because he knows that that breaks down group pride and group morale. He keeps men in his trust by telling them the plan of action; he gives warning orders; he mingles with

¹ “Time,” from advertisement of Russell Birdwell in *Pittsburgh Medical Bulletin*, Vol. 31, December 26, 1940. p. 873.

² See “The Glory of the Soldier,” by Major T. R. Phillips. *Coast Artillery Journal*, Vol. 82, pp. 194–205, May-June, 1939.

and knows his men; he is concerned about their comfort. His every action is one that shows his men that he trusts them and relies on them.

By inculcating the "one for all and all for one" principle in the minds of his men, the leader builds up the loyalty so necessary on the battlefield. He knows that when contentment of mind and good morale are present, proficiency in military training will naturally follow. He knows that discipline of character and maintenance of morale form the basis of the will to fight, and that this is the only kind of discipline that will stand up under the trials of combat.

III. MILITARY DISCIPLINE

"Military discipline constitutes the glory of the soldier and the principal force of armies," wrote the great French militarist, Carnot, in 1811. The term discipline is derived from disciple. Originally it referred to instruction imparted to disciples; thus it meant a particular course of instruction. From this, the word evolved to mean "instruction having for its aim to form pupils to proper conduct or action by exercising them in that instruction." At this stage it was used to signify "training in the practice of arms and military evolutions." Soldiers were punished when they broke ranks or got out of step, and punishment given for infractions of discipline (drill) became known as disciplinary punishment. When a unit drilled well, it was said to be well disciplined—that is, obedience was prompt and simultaneous. So finally discipline became associated with obedience and control.

To-day, Webster defines discipline as control gained by enforcing obedience or order, to the end that in time of stress all duties are performed without thought, on command, like a machine. But an automaton is useless in war to-day. New battle conditions demand a change in discipline. Battles to-day depend on a fighting soldier with individual initiative and morale. Unlike the soldier of yesterday, he does not attack *en masse* with others. He is a cog in a team whose action depends on the individual effort of each man. His mental and physical powers may be tried for hours and days, and he may have only the resoluteness of his heart to sustain

him. It is the mind that wins battles. Discipline of character, of morale, is the only discipline that will stand the strain of modern warfare.¹

The citizen soldier of to-day, moreover, is not suited to the ancient discipline of blind obedience without explanation, which in turn is not suited to modern war. He will resent the old discipline and hate it; he will accept it from patriotism as the worst of war's horrors; he will realize its futility and turn his dislike against the people who enforce it—his officers. And this, despite the fact that the young American who comes into the army today is disciplined. "He has gone to school and arrived promptly at 9 A.M. for five days a week, nine months a year, for eight, twelve, or sixteen years. He has done study assignments at home without perceptors over his shoulder. He has learned leadership and coöperation in group games. He has driven a car and knows the discipline imposed by traffic. In short, he comes to the army with the elements of just the right kind of discipline the army needs: he submits to necessary authority, but maintains independent action within limits; he obeys willingly and intelligently when he knows the need for obedience."²

And yet our basic methods are sound. "For instance, given a group of men for a certain time, army methods can turn it into a military organization, so well controlled and integrated that it can be handled as a unit. Something happens to these men during that training period, changing them from a loose collection of civilians into a compact fighting outfit. Generally, we are satisfied only to know it occurs and the method used to obtain it is sound; and if pressed for a word to define the result of this military process, the answer is, 'The men have acquired discipline.' But discipline, as it evolved, means anything from a process of training to a scheme of punishment. It is doubtful, therefore, if the word discipline in itself, as generally used, defines completely what has happened to men."³

Is the reason for their conversion the acquired skill in the

¹ Major T. R. Phillips, *op. cit.*

² *Ibid.*

³ "The Place of Psychology in the Army," by Captain J. H. Burns. *Infantry Journal*, Vol. 33, pp. 254-62, September, 1928.

technique of arms, or the unity that comes from living together, obeying the same leaders, finding confidence in one another? Yes, but only partially so, for discipline does not mean only the habits of action, the automatic behavior patterns, learned by constant repetition in training. It means, too, the sentiments of duty, the will to sacrifice, the voluntary acceptance of obligations, the moral forces involved. Moreover, without the spiritual motivating portion of this definition of discipline, the mechanical-action part is either impossible to attain or is poorly attained. The true military leader, who indoctrinates men's minds first, knows that military efficiency in the technique of arms will certainly follow. The martinet, who either *does not* or *will not* understand that basic mental contentment is necessary before intelligent obedience can be had, never gets the loyalty of his men that true discipline implies.

The mental change, therefore, that occurs and develops under the military process, the change that trains the feelings of men to supply a motive force strong enough to make them face the rigors and dangers of war, loses its mystery if we remember that true discipline rests on a firm foundation only when based on good morale. The purpose of discipline then, in the light of this definition, is first to prepare men's minds and spirits, then to train their bodies to do the right thing at the right time during combat. Only when discipline implies morale, too, will training be so well ingrained that mind and body will function automatically even in spite of the noise and confusion of battle. Only then will the finished products of good discipline be men who are physically fit, mentally alert, and endowed with the highest loyalty and spirit. Only then will discipline be the means to victory!

PUBLIC RELATIONSHIPS OF THE MENTAL HOSPITAL

J. W. Klapman, M.D.

Senior Physician, Chicago State Hospital

AS LONG as the rôle of the mental institution is conceived to be entirely, or mainly, custodial, it is its relationship to the patient that constitutes the sole therapeutic concern. Change the therapeutic outlook to the rehabilitation of the patient and his reintegration into society, and a number of new factors loom up to claim our attention urgently—and to complicate the problem considerably. Instead of the therapeutic relationship's being confined to doctor and patient, it becomes a triangular relationship, including the near relatives, and, less directly, a quadrilateral relationship, including the public in general.

The relationship of the mental hospital to the public, the relationship of psychiatry as a whole to the public, is often alluded to as a matter that needs close scrutiny in dealing with the problem of mental disorders. But it is sometimes surprising to note with what skepticism the doctor often approaches this aspect of the practice of psychiatry. One readily senses that it is deemed dangerous territory. Is it not probable that this attitude resembles in some degree that of the medieval medical man, who would not bemean himself by doing any surgery, but called on the barber to perform that menial task?

The problem of public relations is a more or less acute one for the mental hospital, for it is an especial target of public animosity, and despite the genuine and marked progress achieved by the modern mental hospital in the last few decades, there is relatively little reduction in the animus and suspicion with which the public regards these institutions. This is particularly true of the press, which, always with an ear close to the ground, has in the past gone to the extreme of planting observers in this or that institution

as patients in order to publish disquieting reports about the conduct of these hospitals.

Not so long ago—some half-dozen decades or so—the general hospital suffered from somewhat the same handicaps, although from a rather different set of causes. The general hospital has overcome this disadvantage in every modern community. Is it not reasonable to expect as much in the case of the mental hospital?

To know the origin of some of these hostile attitudes is at least to have acquired a prerequisite for their correction.

The attitude of the public toward the mental institution has a unique basis. One's first assumption would be that it is due to concern for the allegedly mistreated inmates, but such possible concern is inconsistent with the stigma and the disabilities heaped on any individual with a record of mental-institution hospitalization; just as there is an inconsistency between the fairly widespread credulity as to the prevalence of "railroading" innocent victims into an asylum and the treatment accorded known ex-patients of such institutions. For if the practice of "railroading" is as widespread as is believed, the probabilities that any particular ex-patient has been a victim of it might at least entitle him to a stay of judgment.

But the point need not be labored. Freud has shown that such attitudes are in reality displacements of guilt feelings—a displacement in this instance on the mental hospital itself first, and secondarily on its personnel.

To all such aspersions, our answer is a dignified silence. But that may not always be enough. Silence may be interpreted as assent, and certainly in this branch of medicine, which concerns interpersonal relationships—the patient's relatives, by common agreement, often needing treatment as much as the patient himself—this neglect of public relations is a singular oversight.

There is no evidence that the problem of public relations is not as amenable to study and improvement as any other human problem. Nor is there any escaping the fact that such study and improvement are a legitimate task and obligation of psychiatry.

To begin with the aspect of the problem that is closest

to the mental hospital means to study the typical reaction patterns of relatives and friends of patients. It is obvious that there are notable differences between the public relations of the general hospital and the public relations of the state mental institution. The principal differences are as follows:

1. *Organic diseases* are the chief concern of general hospitals. These do not, in most cases, require a very long period of hospitalization. They do not usually involve such unfavorable relationships with the hospital, at least not the same kind of psychological dynamisms. Organic illnesses focus attention on a different phase of hospitalization.
2. *The chronicity of mental disorders* means that a long and often permanent contact is maintained with the hospital by the relatives as well as by the patient. The relatives get used to the hospital personnel, and "no man is a hero to his valet." Moreover, because most mental patients are ambulatory and the hospital perforce takes charge of a variety of their activities, many more "friction points" are created.
3. *The paucity of therapeutic disciplines* generally practiced in state mental hospitals that relatives may plainly recognize as "treatment" is another factor that the mental hospital must deal with to a greater extent than the general hospital.
4. *The stigma of mental disease* is an ever-present obstacle to favorable public relations for the mental hospital. The importance of this factor is hard to exaggerate. It rears its ugly head in a thousand places where mental disorders and mental patients are concerned.
5. *Non-medical personnel* must be depended upon for the administration of much of the treatment in a mental institution. Such employees are often poorly trained and poorly oriented to their work.

These differences and existent attitudes result in, and accentuate, certain well-defined patterns of reaction in relatives. These patterns are encountered with sufficient frequency to warrant classification as types. However much relatives may suppress certain of their reactions, traces can be found in almost all relatives, with few exceptions. It would seem logical that, as a first step in dealing with the

mental hospital's relationship to the public, these characteristic psychological reactions of relatives and friends should be known and fairly well understood.

1. *Guilt Projections*.—A most common difficulty arises from projections of guilt feelings on the part of relatives and friends, because of the supposed dastardly crime of "signing the patient in." Let him who questions the strength of popular prejudices, taboos, and conventions consider the awesome act of having a patient committed to an "insane asylum." Mayhem and murder pale into insignificance beside this fearful act of "signing a patient in." This is largely a reaction of the average person to the dark mystery of mental disorders, involving also uneasiness with regard to the talion principle. "If that person can be adjudged insane, what is to safeguard my continued freedom in society as a 'sane' individual?" is the unconscious thought that besets all those intimately concerned with the patient.

At the time of the acute psychotic manifestation, the urgency of the case shuts out of consideration these fearful scruples. After a lapse of time, with the recollection of the circumstances that led up to the commitment becoming less painfully acute, and especially with the abatement of the acute phase of the psychosis in the patient, the guilt feelings become more or less dominant. Throughout the rest of the hospitalization, unless a good rapport has been established with the relatives, there are constant and persistent attempts to find displacement objects for this sense of guilt.

This is commonly shown, for example, in the invariable attempt to find a scapegoat for any injury incurred by the patient, no matter how obvious it may be that the injury is self-inflicted or due to an unavoidable accident. An extreme example of object displacement may be noted in the following case:

A well-dressed, apparently well-to-do, personable young woman pays a visit to her aging mother, who is classified as psychosis with cerebral arteriosclerosis. This is a very rare visit, probably the first in several years. The visitor complains most bitterly about the care given her mother, and particularly about the fact that "crazy" patients care for her mother. She sees the ward doctor and complains with great vehemence that her mother was beaten "black and blue" by the patient

ward worker. She demands redress from this outrage and insists that her mother be cared for by employees.

The ward worker is called for investigation. Frightened and quaking in her shoes, this patient appears before the doctor. No, she had not mistreated the visitor's mother; she had only led her to a chair and sat her down—gently.

The supposed victim, the visitor's mother, is now brought for questioning. She is a quiet, mouselike elderly woman, somewhat confused. There is not a sign of discoloration or contusion on her person. This patient herself denies any mistreatment.

The more the baselessness of the visitor's accusations is demonstrated, the more aggressive and threatening she becomes. She begins to swear roundly like a trooper, and is referred to the managing officer.

At the office he tries to explain that the institution must depend partly on patient help, and that patients are carefully selected for that purpose. But there is no reasoning with the woman. When the suggestion is made that she take her mother out of the institution, she counters:

"No, I will not take her out, and you'll have to take care of her!"

She swears more violently than ever and threatens to have the managing officer beaten up. She finally has to be ordered off the grounds.

2. Aggression from Sense of Shame.—When the guilt component is less marked, aggressive behavior may be less evident, but an uneasiness and defensiveness in the visitor's attitude to the institution and its personnel can often be detected. The visitor or relative is often quick to detect any possible aspersion on the family scutcheon. In more obvious forms, this defensiveness may be shown in a ready inclination to take umbrage, to see or to feel in the most innocuous occurrence an attempt to "look down on" or to "high hat" the visitor. In milder forms, it will often be seen in the visitor's launching on an "all-out" account of the respectability of the family, their social achievements, the patient's fine background, and so on.

Patently, this is a reaction to the stigma of mental disorder and the popular notion as to the invariable inheritability of mental disorders. There is also the popular confusion between the psychoses and feeble-mindedness. These facts explain the constant and arduous search for physical traumata as a cause of the mental disorder.

Another result of the occurrence of mental illness in the family is the attempt, often quite conscious, to make the doctor "jump through the hoop." In its mildest form, it consists of trying to turn the doctor into a "yes man," getting him to agree to pet etiological theories. "I think

he broke down because he studied too hard. Isn't that right, Doctor?" or, "Doctor, you see I never had an education and I don't know those medical terms."

These mechanisms accomplish a twofold purpose. The visitor demonstrates his humility, while at the same time the doctor acts on the visitor's behest or command—is subservient for the time—providing the visitor with a fleeting sense of power and bolstering his ego. That establishes the visitor's supremacy and compensates him for the sense of shame.

That the protestation of humility is not always based on the manifest content may be seen in the following instance:

Doctor: The patient is suffering from hardening of the arteries.

Visitor: You mean arteriosclerosis?

In another case, a young man of twenty-five or thirty years of age comes in with a letter from the hospital in which permission is asked to perform a gynecological operation on his mother. The doctor in charge of the gynecological service is absent and another member of the staff undertakes to see the visitor.

The doctor learns that the relationship of the visitor to the patient is that of son, and remarks that it is really up to the husband of the patient to give consent for the operation. The doctor learns now that the father is waiting outside in the car—didn't want to come in; but the son would like to know what the operation is about.

Doctor: The operation is for female trouble.

Visitor: What's that?

Doctor: To repair the female organs.

Visitor: Repair! What kind of operation is that?

Doctor: It's an operation to repair the organs.

Visitor: Well, what kind of repairs?

Doctor: Probably a suspension and fixation operation.

Visitor: (Laughs.) Gosh, those medical terms! I can't understand them.

He did not give permission for the operation, and his behavior, and the fact that the father, the responsible head of the family, had remained outside, clearly indicated that the family never seriously contemplated giving permission for it. Nor is it possible to believe that this visitor did not understand what is generally meant by the term "female trouble." Any further or more detailed explanation cannot

involve anything else but a discussion of surgical technique, and this he surely did not want. Which leaves only the conclusion that he had been led to make the inquiry out of curiosity and a desire to make the doctor "jump through the hoop."

3. Neurotic and Anxiety Reaction Patterns.—In the case of individuals with definite psychoneuroses, the physician is often fixed upon as a possible anxiety-allaying object. But as in the hand-washing mania, the mechanism fails here also, and thus no amount of reassurance and no suggestion that the doctor may offer goes undoubted or undisputed. Not infrequently the neurotic relative may leave no stone unturned to have the patient released, despite the most reasonable protestation of the doctor or the demonstration of the absolute inadvisability of taking the patient out of the institution.

As soon as the parole is granted, doubts begin to assail the relative. Not infrequently the patient will then be left in the institution; only to have the whole circle of anxiety and doubt about the parole begin again.

4. Oversolicitousness for and Rejection of the Patient.—Oversolicitousness of parents and relatives for the patient is possibly a trite subject, but still in many cases a most potent factor to be considered. It may be remarked that the suspicion of rejection of the patient in the presence of oversolicitousness is hard to allay when one notes with what avidity relatives will seize upon any symptoms, fancied or real, that the patient may show. On one occasion, the visitor will anxiously inquire whether the patient isn't suffering from a serious heart ailment; the next time he is certain that the patient has contracted tuberculosis; and on still another visit, he is sure that it is a gastric carcinoma. The eagerness with which on almost every visit the relative will report some new serious ailment tends to indicate that he would like to find some organic cause for the psychosis and thus lighten the weight of the stigma, and also that "hope springs eternal in the human breast"—e.g. an unconscious hope that the patient might be carried off by some intercurrent disease.

This may be noted also in the grim determination with

which relatives will stuff a patient with five times the amount of food any individual could consume for any one meal, frequently causing him gastroenteric disturbances the following day, and altogether making him a noticeably sadder, but not wiser person.

In the same way relatives will gather about the patient on visiting days and set up a "wailing wall" around him. As a result, the patient not infrequently becomes agitated and disturbed, a consequence obvious to attendants and others, but not to the relatives. After the patient has been rendered properly agitated and uncoöperative, the relatives may run to the attendant demanding that something be done for him.

5. *Conflict of Attitudes.*—Certain preconceptions of the rôle of the hospital in the treatment of the patient are bound to impose special difficulties in the hospital's relationship to the public. The average person quite easily falls into the attitude of regarding hospitalization in a mental institution precisely as he would that in a general hospital. This is no doubt quite natural. Thus questions arise about the minutiae of the patient's physical, mental, and moral condition, which it is up to the doctor to answer on demand. It is self-evident that even with only one hundred and fifty patients to the doctor, the ideal standard to date, it is impossible for the doctor to know every minute detail of every patient's circumstances, to say nothing of his clothing needs, his personal effects, and his innermost thoughts. Yet, officially, the fiction that the doctor has all this information at his fingertips is maintained in unmodified form.

Obviously, in the routine management of patients, state-hospital therapy is not too well individualized. But a greater degree of mass therapy is possible than is generally realized; which therapy may be expected to result, to a large extent, in a resolution of the conflict. In the meanwhile, the doctor is left to manage the situation as best he can—viz., to maintain to the relatives the fiction that he is administering a most thorough individual and personal therapy, when he knows his patient only superficially and in the mass. Questions directed to him of a specific personal nature he must answer with a show of knowledge that he could hardly possess.

It is a disagreeable aspect of the hospital's relationship to the public and it is seldom mentioned. But if a serious attempt be made to study that relationship, it cannot be ignored.

There are two aspects of the resultant bad effects that stem from this conflict of attitudes—to wit: the effect upon the doctor and the effect upon relatives and ultimately upon the public in general.

The maintenance by the doctor of what is, in bald terms, an attitude smacking somewhat of duplicity, is extremely corrosive. There is not much value in a counsel of perfection—namely, that the doctor remedy the condition by sheer force of character or power of will. The physician with two, three, four, or five hundred patients under his care, feeling the futility of attempting the much-to-be-desired individual care, will often, even if gradually and unconsciously, slip into an indifference that precludes an inclination to do even that which is possible. Thus the equivocal situation growing out of the conflict of attitudes exercises a corroding effect on the morale of the staff physicians. It is no theoretical postulate that a deep-seated aversion to the mental hospital, and, indeed, to the whole practice of psychiatry, in the case of many physicians, arises partly from the aforementioned factors.

On the part of the relatives, the fiction or convention is maintained more or less willingly out of a compulsion to compensate in some way for the fancied or real injury done to the patient by reason of the commitment. The relative is already unrealistically compensating or overcompensating for the fancied wrong, and he is not the one to point the finger of scorn at the hospital personnel on that score. What Freud has called "the corruptibility of the super-ego" conduces to this exchange of equivocal attitudes. Nevertheless, relatives will occasionally indicate that they are cognizant of the real situation by remarking, "Of course, you have so many to take care of," and so on.

Parsons¹ has made the same observation on a wider social scale:

¹ See "Propaganda and Social Control," by T. Parsons. *Psychiatry*, Vol. 5, pp. 551-72, November, 1942.

"Underlying all this is a most important consideration. In ordinary social relations it can be said that there is a mutual obligation to take the other party at his face value, to 'take him seriously,' as it were. It is this very obligation, and its reciprocal expectations, which creates a primary opening for the operation of the vicious circles which may eventuate in neuroses, for by distorting the cognitive definition of the situation by rationalization, by concealing—usually unconsciously—actual motives and putting up an acceptable front, one forces others into fulfillment of the obligations of their statuses and rôles although one is not 'really' in terms of actual social values entitled to this fulfillment."

The Institution's Defense: Obsequiousness. To the differences that arise from this conflict of attitudes, almost the sole defense of the institution is a greater or less degree of obsequiousness. This hardly helps to dispel the tendency of relatives and the visiting public to equate the hospital with a department store. Any time a relative chooses to call for information, the doctor must be there to serve him. Telephone calls can be made at any time, conferences sought and granted at any time. It makes no difference what the doctor may be doing at the moment—the caller must be seen without delay. Requests that are not absolute impossibilities must be granted. Requests for the transfer of a patient to a different ward, no matter how unsuitable and no matter how much he may disrupt the orderly conduct of that ward, must be met.

Such obsequiousness is predicated on the idea that to grant requests at all costs will appease relatives. Like most appeasement, this is apt to fail ultimately, for certainly one thing that appeasement does not do is allay neurotic anxiety. A simple example will prove the point. When a relative inquires when he may visit the patient, one need only answer, "Any time." The result is sometimes a near-panic, with the counter question: "But when shall I come? What are the visiting hours?"

Other results must also inevitably follow. If the doctor can be interrupted at any time by unlimited telephone conversations or by interviews at the office, waiting to serve the visitor like a department-store clerk, his professional work cannot be very heavy or very important. And one need not look far for expressions of this very attitude.

This does not constitute a defense of rudeness and discourtesy toward visitors. It only argues against an unrealistic approach to the hospital's relationships with these visi-

tors—an approach that not only fails of its object, so far as the relatives and the public are concerned, but that also, in the long run, proves to be a definite deterrent to adequate treatment of the patient.

A little consideration must also be given to the net effects on the hospital personnel of the irritants arising from present relationships. Is it always sound advice or policy to swallow or repress one's irritation and anger?

Staff Resistances.—Staff physicians, like most other human beings, have their resistances and apathies; for which reasons, they also must find scapegoats. The scapegoat *par excellence* is "polities." But "polities" is not the sole or even the major difficulty. For, to begin with, it would appear that staff physicians have a profound disinclination to the study of group manifestations, because such study is regarded either as unscientific or as outside their own particular province. A common-sense approach would dictate that the factors that interfere with the desired results be investigated and removed or remedied, regardless of their character.

Other resistances grow out of a conviction of the abstractness of psychiatry (abstractness so often being equated with invalidity), of its exclusive use of unfounded interpretations, personal complexes, and biases. These resistances serve many purposes, but chiefly they act as a protection against the need for changing the *status quo*.

Is there no reconciling these divergent attitudes?

Presumably, interviews with the relatives by staff physicians should have this effect, but the conditions of such consultations usually constitute a poor setting for the necessary education of the relatives. Usually the request for the interview is not prompted solely by a search for "information." Rather is it a rationalization or projection with which the relative approaches the consultation, with the result that the doctor is forced on his guard. This is not a very good therapeutic setting.

Relatives often feel that the doctors are banded together in the pursuance of some strange and probably very sinister design. Not infrequently a visitor will remark: "Now, Doctor, please tell me the truth," though what a physician in a public institution could conceivably gain by withholding the truth, it is hard to see. There is thus manifest profound

resistance to any of the doctor's statements, suggestions, or reassurances. Rapport is often lacking. For the desired effect something more in the nature of a therapeutic situation is required, free from the suspicion of self-interest on the part of the doctor, and presenting the material, as it were, from a neutral point of view.

Group phenomena must come in for closer study. Moreno,¹ Redl,² Burrow,³ to name but a few, have more than hinted at the powerful forces at work in the group. If the state hospital, under present circumstances, cannot offer highly individualized therapy, it can find at least partial compensation in the utilization of group factors. Marsh,⁴ Wender,⁵ and Low⁶ have demonstrated that it is quite possible to take the public at least partially into our confidence, with gratifying therapeutic results.

The patient is not the only possible beneficiary from the utilization of group factors. What of the hospital personnel? What of group interactions in the various classes of institutional employee, and the resulting lack of integration of their efforts? Rowland⁷ has shown some of the interaction processes among the hospital personnel. Even the staff of psychiatrists is often so broken up in their attitudes, beliefs, and personal interactions that their total therapeutic influ-

¹ See *Who Shall Survive?* by J. L. Moreno. New York: Mental and Nervous Disease Publishing Company, 1934.

² See "Group Emotion and Leadership," by F. Redl. *Psychiatry*, Vol. 5, pp. 573-96, November, 1942.

³ See "The Group Method of Analysis," by T. Burrow. (*Psychoanalytic Review*, Vol. 14, pp. 268-80, July, 1927.) See also his paper, "Social Images Versus Reality." (*Journal of Abnormal Psychology*, Vol. 19, pp. 230-35, October-December, 1929.)

⁴ See "Group Treatment of the Psychoses by the Psychological Equivalent of the Revival," by L. C. Marsh. (MENTAL HYGIENE, Vol. 15, pp. 328-49, April, 1931). See also his "An Experiment in the Group Treatment of Patients at the Worcester State Hospital" (MENTAL HYGIENE, Vol. 17, pp. 396-416, July, 1933) and "Group Therapy and the Psychiatric Clinic" (*Journal of Nervous and Mental Disease*, Vol. 82, pp. 381-93, October, 1935).

⁵ See "The Dynamics of Group Psychotherapy and Its Application," by L. Wender. *Journal of Nervous and Mental Disease*, Vol. 84, pp. 54-60, July, 1936.

⁶ A. A. Low, editor of *Lost and Found*, the magazine of the Association of Former Patients of the Psychiatric Institute of the University of Illinois and of the (Illinois) Department of Public Welfare.

⁷ See "Friendship Patterns in the State Mental Hospital: A Sociological Approach," by H. Rowland. *Psychiatry*, Vol. 2, pp. 363-73, August, 1939.

ences is considerably dissipated. It is erroneous to believe that what happens between staff members never trickles down through the several strata of the hospital hierarchy to the patient.

The study of mass influences is not only an alternative; it is an imperative. For the psychiatrist must come to realize that the "social atom" does not circumscribe the totality of the problems of mental disorder. The "social atom" is but an infinitesimal part of the social organism; the whole apparently is greater than the sum of its parts. The study of the atom alone will not reveal the influences exerted on it by the organism as a whole, and without these modifications and influences, the behavior of the atom cannot be understood in its entirety.

RECOMMENDATIONS

A few characteristics of institution-public relations have been outlined. This phase of the hospital problem is as amenable to study and observation as any other problem in psychiatry, and, by the same token, remedial measures are just as likely to be derived from such study. A few measures that might be suggested here are:

1. *Setting up a means of studying public relations and group interactions.*
2. *Definite visiting hours.* Definite hours for visiting should be maintained at each institution. Also, it must be the privilege of the hospital to deny parents or other visitors access to the patient when this is deemed to be in the patient's interest. Every doctor has had the experience of observing the effects of chemo- and psychotherapy neutralized and destroyed by ill-advised visits to the patient.
3. *Definite hours for consultations and telephone calls.* The doctor could better apportion his time if certain hours were reserved for consultations and telephone calls. As it is, the needless interruptions of other duties—and especially the concurrence of several immediate demands from the wards and a long-drawn-out consultation for the major purpose of soothing a relative's ego—is a wasteful expenditure of human effort and a serious drain on the doctor's energies, interests, and scientific enthusiasms.

4. *The use of the printed word.* In some quarters the use of language has earned for itself a very much undeserved obloquy as the antithesis of action. More use should be made of it in the treatment of the patient.

(A) In any commercial enterprise of any size and in any academic institution of any standing, the printed word, in the form of a prospectus, is usually employed to give information to prospective clients. The prospectus usually describes services and equipment. It would seem logical to adapt the same means to state-hospital purposes. Relatives are usually anxious to obtain reliable information to enable them to orient themselves to the occurrence of mental illness in the family. In a booklet, such information tends to reach the relative in a neutral, disinterested manner, and with sufficient authority to carry much weight. It should help to establish a desirable relationship.

(B) An institution (house) journal for relatives, patients, and the public may seem a puerile suggestion, and yet in essence this is the type of medium through which a large part of medical education is usually acquired. An institutional house organ, used with skill, tact, and dignity, will help to raise the tone of institutional life, quicken it, discover new qualities and assets in its patient contributors, and convey a greater sense of coöperative effort to the relatives, with a consequent increase in rapport. For the relatives it can become one of the few reliable sources of information about mental disorders and mental institutions.

5. *The organization of relatives and recovered patients.* Experience with such organizations as have been formed by Marsh, Wender, and Low has more or less conclusively demonstrated their value in the treatment of patients and in the conduct of the institution. Relatives and patients take kindly to the idea, and there is tolerant curiosity about it on the part of the general public. A far better rapport is thereby established than is possible under our present methods. To date, no better method has been evolved for "educating the public."

6. *Group psychotherapy.* Group psychotherapy is the logical and effective method of treating patients *en masse*, a recourse indispensable in a large institution.

Group treatment includes many other measures that, while

of secondary and of subsidiary importance, are by no means negligible. One noteworthy characteristic of the large-hospital atmosphere is the dull, flat level of its emotional and intellectual life. As Myerson¹ has stated: "It is here claimed that hospitalization of a patient under the circumstances of the care usually given produces 'prison stupor' or prison psychosis which interacts with the social retreat of the original schizophrenia. Schizophrenia is, in certain of its characteristic manifestations, a retreat from social contact into delusion. . . .

"He [the schizophrenic] is immersed in monotony, and perhaps, most importantly, he lives in a *motivation vacuum*. That is, reward and punishment disappear from his life."

One can devise mass enterprises that make room for initiative and incentive in the patient's life. For example, it would seem possible and even logical to classify the institution's population into several grades, with the opportunity held out to the patients of being promoted from a lower to a higher grade—a simple strategem, but potentially useful. Prizes for proficiency in various hospital enterprises still have much appeal to a large number of the institution's population.

Group psychotherapy itself is gradually coming into wide acceptance. A growing literature testifies to its value.

Such measures invariably gain the approval of relatives and of the public in general. So far as the patients are concerned, it is noteworthy that a different attitude develops in them than what was formerly common. Patients so managed in the hospital frequently come back after release to revisit the familiar scenes; they appear to enjoy the "reunion," very much as "old grads" revisit their alma mater.

In conclusion, it should be emphasized that the counsel of perfection that the doctor take a keen personal interest in the patient is sterile advice, for without any other point of approach, how does one begin to take a personal interest in two or three hundred patients? Group psychotherapy offers this opportunity, even though in a limited way. It must not be overlooked that the transferences achieved in group ther-

¹ See "Theory and Principles of the Total Push Method in the Treatment of Schizophrenia," by A. Myerson. *American Journal of Psychiatry*, Vol. 95, pp. 1197-1204, March, 1939.

apy work two ways. It is impossible to administer group psychotherapy conscientiously without seeing in the patient a human being laboring under a specific set of difficulties. Even a feeling of concern for the personal welfare of the patients and something approaching genuine affection for them as human beings is a logical corollary and a natural outgrowth. That is one of the best natural guarantees of good personal attention to the patient.

THE PSYCHOLOGIST WORKING WITH CRIPPLED CHILDREN

RUTH M. HUBBARD, PH.D.

Psychologist, Consultation Bureau of Detroit, Michigan

THE social agency that deals with crippled children attempts to work out for each child under its care a reasonable and satisfying plan of living, a plan that will help the child to face his limitations realistically and to use all his available capacities, a plan in which the child himself participates. Each of the various specialists working with the crippled child and each of the resources in the community has a contribution to make toward the formulating or the carrying out of this plan. Here we will speak of the part the psychologist plays in such a program.

Ordinarily we think of the psychologist's function in school or social agency as primarily diagnostic, determining for parent, child, teacher, and social worker what is the intellectual equipment of the individual with whom they are working. In work with a crippled child, the diagnostic function is easily apparent. In order to help him work out plans for himself we need to know the crippled child's general level of ability, and to know it in such terms as to make him immediately comparable with specific groups of individuals—the general population, his own school and neighborhood group, the members of his family. This comparison makes apparent the approximate amount and type of competition he is likely to meet in intellectual tasks within the various circles of his social milieu. Tests of general intelligence may also provide information as to the relative abilities of the child—for example, whether he deals more easily with words or with numbers—and the distribution of abilities within the child may suggest lines for further exploration in the determining of educational and vocational plans.

The results of intelligence tests become one aid in sorting out the factor of ability from the environmental and cultural handicaps that these children may have experienced. They

are more apt to suffer environmental handicaps than are normal children of the same socio-economic level since their physical handicaps so limit their external contacts. Parents, in their solicitude for a crippled child, tend to protect him more than his physical state demands and more than they protect a younger child in the same household, so that he has not the variety of contacts his siblings may have. Or he may have spent the major portion of his life in a hospital or a convalescent home, so that by the time he is seven years old, he does not know what the kitchen in a home looks like or how its various pieces of equipment are used.

One such seven-year-old, returning to his own home after five years in a hospital school, was very much frightened at seeing his father light his cigar. Test results on such a child are to some extent invalidated by his lack of the experiences normal to children of his age, but the test results are in turn the first step in learning his capacities for making fuller use of environmental opportunities.

Tests may serve a further function in helping to determine to what extent apparent retardation is due to intellectual limitation and to what extent to emotional dependency. A young man, slightly handicapped, was referred for vocational testing because, in spite of several efforts to secure a job and the statement by his school that he was trained for work, he never seemed to connect with work that he could do. The test findings indicated average intelligence and adequate mechanical ability, with inconsistent work habits. His conversation during and after the tests, however, gave more important information than the mere ratings. He very deeply and thoroughly doubted his ability to do anything, expecting failure before starting; his comments about his home suggested that he had been allowed to evade responsibilities that as a growing boy he might gradually have assumed and that a younger brother had assumed. At nineteen he was anxious to take responsibility for himself, but felt totally unready to do so—had no idea of how to take hold of and use events. Since his innate potentialities were rated as average, it seemed worth while for the adults interested in him to give him considerable help in a step-by-step assumption of responsibilities in his work and in his personal life.

In working with crippled children, there are some limitations to the use of the usual individual intelligence tests, since the child's physical handicaps affect his ability to manipulate or to respond to the usual materials. His ability to rate on tests is dependent upon his ability to express himself *somewhat*, through words or through motor activities, such as pointing, gesturing, piling blocks or stringing beads, or even glances or head nodding.

One twelve-year-old boy, exceedingly restricted by severe birth injury and by lack of interest or stimulation from environment or family during the whole span of his life, rated at the three-year level on the Binet test. His failures seemed to be due not only to his speech difficulty and his motor limitations, but to actual lack of comprehension of what was asked. He pointed, but pointed wrong; though he piled blocks steadily, they did not make a "bridge." His ability to do for himself ("social maturity," as indicated by the scale devised by E. A. Doll) was infantile, far below even his mental age. There was considerable doubt about the validity of his test rating; so, to evaluate his possibilities further, he was placed at the hospital school that forms a part of the training facilities of the Detroit Orthopædic Clinic. He was given aid and incentive toward greater motor activity and showed quick and definite response in terms of interest and increasing skills. As his skills approached his mental age, their speed of acquisition leveled off and it became apparent that even in the face of his difficulty in expressing himself, the Binet test rating had been a fairly accurate indicator of his ultimate educability.

In the case of such severe orthopedic conditions as this, we cannot be sure to what degree our rating is accurate, but it gives one level of expectation for the child, a level to be checked by all the other facilities at our disposal. For such children, too, the evaluation of intelligence is primarily a measure of the present functioning level—a minimum measure rather than a full prediction for future development.

Measures of the intellectual level of birth-injured children may be expected to be the least valid of any testing done (except possibly the testing of psychotics), because of the extreme difficulty such children have in expressing themselves,

and because of the examiner's difficulty both in understanding the expression the child can produce and in estimating to what extent it indicates his optimum responses. The question then arises, "How fair is it to use with birth-injured children a scale that was standardized on normal children?" This same question arises in connection with the testing of any minority group and the answer is the same for all minority groups. We are not interested in knowing how *this boy* could compete if he were *not* handicapped, but in knowing how, *with his handicap*, he can compete with normal people. In what ways or to what degree is he different from other boys? What capacities has he that can be utilized in working among normal people? Only by comparing him with normal boys can we help him fit into the community as it is.

As an aid in planning for birth-injured children, we have scrutinized the results of tests given these children for the Detroit Orthopædic Clinic to see how constant the ratings have been. The twenty-six children to whom at least two Binet tests have been given showed a median change of +1.6 I.Q. points between the first and the last test; the median amount of change, regardless of direction, was 9.7 I.Q. points. For ten children, the retest I.Q. was within ± 5 points of the first I.Q.; two children showed changes of 20 points, one an increase and one a decrease. It is true that some of the constancy in these ratings represents not the constancy of the child's intellectual growth, but merely the constancy of his ability to express himself. If this small sampling is any indication, the change in rating on birth-injured children from test to retest may, 50 per cent of the time, be as much as 10 I.Q. points, and may be in either direction, an increase or a decrease.

An adequate treatment program for crippled children includes careful medical and orthopedic attention and nursing, physiotherapy, training for increasing independence and self-care, academic instruction, occupational therapy, and intensive case-work with child and parents wherever indicated. Under such a program, gains in motor skill, self-reliance, or emotional control are apparent in the children's records and are very important in their development, but are not found to be reflected in higher I.Q. ratings. The I.Q. ratings seem to be largely independent of these factors. They may

be of help in the selection of children to be given the most intensive and long-continued aid, but they cannot serve as measures of the efficacy of that aid. Other measures appropriate to the specific fields should be used where available, the Doll Social Maturity Scale, for example. There is need for additional measures—of emotional control, of persistence and drive toward a goal, and so on—since these factors enter so largely into the child's ability to avoid going "stale" in the course of a long program of physiotherapy.

The psychologist contributes to the working out of educational plans for a child by offering information about his mental-age level, his present level of achievement in specific school subjects, the relationship between his ability and his achievement, and the measurement of intellectual factors that affect his capacity to profit by school training (attentiveness, nervous irritability, reaction to number, shape, linear direction, and so on).

The school performance of crippled children is frequently below what is to be expected of their mental level. This may be a result of real physical disabilities (inability to hold a constant visual focus, inability to write or even to punch a typewriter), of real intellectual difficulties not directly associated with I.Q. level (incomplete lateral dominance, irregular attention, as in some birth-injured children), or of inability to attend school regularly because of surgery and prolonged convalescence or because of the need for special transportation. It is even more apt to be due to emotional problems. Among these may be discouragement or a feeling of inadequacy, sometimes even when the handicap is very slight. Or so much in the way of physical care may have been given to the child that he is not used to doing for himself even what he can do; he remains passive in the school situation as he has learned to be passive in other life situations. Appropriate intelligence and educational measures will help to determine how much to expect of the child, so he can be led to develop his full potentialities.

When a crippled child begins to make vocational plans, again tests may be of assistance, as with any other children. Tests of special aptitudes and of interests provide information as to the possibilities for this child, in addition to comparisons of his various abilities as indicated on his

intelligence tests. The case-worker helps him to integrate all the available information about himself—his intellectual abilities, his interests, his physical capacities, his personality traits, his financial resources, the training resources of the city—into some feasible vocational suggestions.

One boy had, with the best will in the world, been started on a training course in armature winding, but, when tested, he was found to have very poor mechanical ability and good clerical ability, so he was shifted to a more suitable course. Another boy, very unhappy at home, was found to have superior intelligence and skill for work relating to airplanes, in which he was much interested. A definite plan for him, with a job in sight, lessened the pressure and thwarting from his mother, with resultant improvement in the boy's outlook on life.

Suitable vocational planning is especially important for handicapped children. Openings for them are fewer and must be carefully sought, so a single unsuitable placement becomes expensive to employer, agency, and child. Job failure may be especially devastating emotionally to a boy who has never felt quite adequate and has, therefore, looked forward with special hope to the time when he would be earning, would be a functioning member of the community. Vocational success frequently becomes one important means of compensating for other lacks, physical and social.

Statistical findings from tests are the skeleton of the psychologist's diagnostic contribution. She builds a living picture of the child from her observations of his behavior, and from his statements about his own attitudes, opinions, and plans expressed during the testing interviews. Entering into this picture are his habits of work; his reaction to success and failure (whether he easily becomes discouraged, boastful, or show-off); his method of carrying out a continuous task; and his way of meeting difficulties (whether he states that the task is too hard, or the test materials wrong in some way, whether he asks for help, avoids the task entirely, works doggedly without enthusiasm, or is challenged and works enthusiastically with a variety of methods, and so on).

How intense and constant is his attention, and how much is it under control? How much energy does he put into

the task and how systematically and efficiently does he expend that energy? Does he develop a plan for work, and if he does, may the plan be varied or does it become stereotyped?

How critical is he of his work? Must he rely on cues from the examiner's face to learn whether he is doing well or poorly, or can he judge for himself? Does he tend to think he does poorly, no matter what the situation? Does he tend to think he always does well? Or does he recognize where he does well and where he does poorly, either in the testing situation, in school, or on his job?

Does he show dependency on the examiner, for help, criticism, approval, keeping him to the task? Or does he resist any dependency to the point of refusing needed help, refusing to accept approval offered?

What can he do with test findings when their main direction is indicated to him? Can he think in terms of their application to himself, work out the beginnings of plans based on them, or does he expect to be told what to do next?

What sort of relationship does he set up with the examiner? Is she a monitor to keep him to the task, a friendly observer, a timing machine, an authority to be resisted, a person whose help may be enlisted if he can find the way to "work" her, and so on?

In what way does he meet the examiner? This last point is of interest where vocational plans are being considered, since the child's initial reaction to the examiner may be a sample of his initial reaction in employment interviews. It is of interest, also, whatever the problem, since the child's method of beginning this contact may represent his way of meeting any new situation or person. To what degree is he poised? What overflow movement is present? What are his techniques for social response?

These questions suggest, but by no means exhaust, the possibilities for observation open to the examiner during the testing situation. Such observations are constantly being made by the case-worker in the freedom of her interviews. Coming from the testing situation, they are a helpful addition because, by its very nature, the testing is a rather standardized period, much less altered for the individual than is the case-work interview and, therefore, offering more direct comparisons from individual to individual. Further-

more, the nature of testing, with its definiteness and its sense of standards and rules, tends to focus within the child or young person his feelings of inadequacy, resistance, dependency, and so on, so that they often appear here in more obvious form than in the more flexible case-work interview.

As the child comments about tests or school or work, he indicates his evaluation of himself, compares himself with siblings or parents, mentions the cousin who is doing so well in engineering training, or the boy friend who can't get math, "so I do his problems for him." He describes his own situation in school. He may indicate the expectations others have for him, his own expectations for himself, his estimate of his progress in meeting those expectations. He may show his feeling about growing up and about assuming responsibilities—real ones now or imaginary future ones—and the contrast between his feeling about present as compared with future responsibilities may be revealing. Defenses built up become apparent—alibis, evasions, projections, acceptance of dependency, resignation to "fate," and so on. He also probably indicates plans or lack of plan for the future, his recognition of limitations and possibilities.

Again by its very nature the testing situation tends to focus these evaluative efforts by the child. For the first time he may begin to verbalize both possibilities and limitations. The testing is a reality; through the examiner's acceptance of the limitations imposed by the tests and her warm consideration of him as an individual within these limitations, she helps him accept this more or less unpleasant reality. The child's evaluations here overlap what he may be doing in case-work interviews, but still are an addition, worked out as they are in a different setting with slightly different emphases. As he returns to the case-worker, the child frequently must discuss these evaluations further, must integrate them more closely with the rest of his life, and live through step by step the tentative plans made, testing them as he goes and being strengthened by the worker's encouragement and interest to meet the difficulties that arise.

As can be seen by our discussion of the testing interviews, they serve not only the diagnostic function of indicating for child and worker what the child's capacities may be; they also offer the child an opportunity to take hold of and work

on his own life adjustment. So both diagnostic and treatment functions inhere in the psychological consultation and each facilitates and enriches the other.

The child comes for testing with a special purpose in mind. In his talk with the case-worker, testing has been offered him because it seems likely to meet a need he has expressed. In connection with the testing, he has an opportunity to state the problem as he sees it, to articulate plans for its solution, to think through the various probabilities involved in several different plans, to live through the feelings each plan arouses, and also the feelings aroused by being allowed or expected to make plans.

An important part of the forward look, in counseling handicapped children, is finding possibilities that are open to them. So much of their life has been a matter of learning one after another the things that are closed to them. The discussion of the tests should emphasize what is open, either in the way of work or through hobbies and recreational activities. With some possibilities open, limitations do not loom so large.

Furthermore, facing the limitations realistically has a reassuring effect upon the child. The tests do compare him with the vast group of normal children in a variety of ways. He has known that he was inadequate in many ways and has tended to let the inadequacies overshadow all his comparisons of himself with others. Learning with some definiteness just where the inadequacies are and how great they are, and learning at the same time that he has certain specific capacities in comparison with other children, gives him a surer footing in stepping out among others.

A further reassurance is the opportunity to consider the small steps that it is immediately possible for him to take toward the goal he has set for himself. If the goal is primarily in the field of vocational or school adjustment, these steps may be quite concrete; if the goal is a matter of getting along with other people, children or adults, the steps to be taken may never be verbalized, but are felt through in his relationship with case-worker or psychologist. The fact that the steps are small, that no great step need be taken at once, is a reassurance, and as he takes each small step, the one ahead becomes clearer.

The primary need for children with physical handicaps, as for all other children, is that they have the opportunity to accept responsibility for their own life adjustment and help in working it out according to their own capacities for growth.

Parents of handicapped children often need as much help with the problem of being a parent to such a child as the child needs in working out a place for himself. Parenthood can offer plenty of complications, even when no physical handicap occurs in the child. But to have a handicapped child activates varied feelings of hostility, guilt, compensatory over-protectiveness, and so on. The measurement of the child's potentialities helps the parent to see the child realistically, to hold reasonable expectations for him, to accept the child's limitations without expecting him either to bow passively beneath them, or to deny them by entering impossible competition.

Seeing the child realistically includes a comparison of him with his siblings, with neighborhood children, with the children in school, so that the parent becomes aware of just what competition the child faces. Specific difficulties in attention, fluctuation in learning ability, and the like, may be important factors for him to know. Numerical ratings (I.Q., percentile, and so forth) are not given to parents or to children in our practice, since these are apt to seem spuriously definite to them, and absolute levels are apt to assume too great an importance. Comparative data are given; the child is classified as average, above average, slower than average in various functions, and from the parent are elicited descriptions of the child in relation to other children in an effort to sharpen his perception of the meanings of the ratings. There is discussion of the child's mental ability in relation to his physical capacities, his social skills, and his self-reliance, pointing out avenues for further expression of potentialities in the home.

The parent's realistic acceptance of the child usually comes up also in the case-worker's interviews; but the psychologist's discussion of it may still be necessary since the parent frequently must work over the same material more than once in order to clarify it, and since the psychologist has actual first-hand data on the child's intellectual capacities.

The medical men have comparable data on the child's physical capacities and help to clarify this field for the parent. To the case-worker usually falls the opportunity of helping the parent integrate the total picture.

It is exceedingly important to individualize the child on the basis of his *possibilities* rather than on the basis of his *disabilities*. Frequently his distinction as an individual, at home, at school, and in his group of friends, has been on the basis of what he could *not* do. The psychological material opens the way for distinction of him as an individual on the basis of what he *can* do.

The case-worker can help the child or young person put into tangible form the tentative plans he may have made on the basis of test findings. Having specific test ratings strengthens her plea for special educational help, special occupational training or apprenticeship, or for community action to make resources available where they are needed. Various forms of state and community aid may be mobilized when the child's potentialities warrant it.

As a further aid in the case-worker's continuing contacts, the tests offer clues to the realms where the child may have some chance of achieving, of obtaining ego satisfactions. Any such achievements will help him drop out emotional dependencies that his physical condition has fostered, will help him grow up emotionally. The test findings and the child's reaction to discussion of the findings will suggest how much can be expected of him by way of carrying out plans, how constant the encouragement will have to be, and how much help will have to be given him in finding the specific steps necessary to his plan. Evaluations by both case-worker and psychologist may indicate need for intensive help by a psychiatrist in working out serious emotional dependencies, unusually resistant defenses, extreme inability to function near his intellectual level, and the like.

The psychologist working with crippled children, then, contributes one angle of study to the evaluation of the children, supplementing the medical, the orthopedic, the case-work, and the psychiatric contributions. Seeing the child and his capacities realistically helps both child and parent to work out suitable educational and vocational plans for him and also helps them clarify their relationship to each other in terms of the child's limitations and potentialities.

THE MENTAL HYGIENE OF OWNING A DOG

JAMES H. S. BOSSARD

*William T. Carter Foundation, University of
Pennsylvania, Philadelphia*

THIS article is written to present the thesis that domestic animals play an important rôle in family life and in the mental health of its members, with particular reference to the children in the family. It is written from the standpoint of a parent and a layman; I am a sociologist, and do not seek to masquerade as a psychiatrist or a psychoanalyst. The conclusions presented are based upon a series of case studies and observations extending over a period of years. The number of domestic animals that might be included as household pets is legion, ranging from a lion cub to a copperhead snake. For purposes of simplification in writing, and as a matter of loyalty to our personal prejudices, this article is confined to the rôle of the dog in mental hygiene.

1. The dog is an outlet for our affection.) This is its basic service and the chief reason for its presence in most homes. Repressed persons tend to disguise or to deny this interest, or to explain it on other than affectional grounds. "I'm afraid to be without a dog." "It's lonely without a dog." "He eats the scraps." Again, the manifestations of this interest in the dog vary from an occasionally kindly cuff to the most tender solicitude, dependent upon the nature and needs of the person involved. In most families, however, affection for the dog is open and frank, with general agreement that the dog receives more attention and affection than any other member of the family. The therapeutic significance of this seems very obvious and very great, and the growing conventionality and impersonality of contemporary life make it of increasing rather than of decreasing importance.

2. Moreover, the dog serves each of us according to our respective affectional needs.) Not being able to speak or to argue, the dog will not say the wrong thing to dampen our

ardor or to spoil the rapport of the moment. Little Jane, out of sorts because her friend, Mary, will not play her way to-day, finds solace with her Scottie. Jack hates girls, mother is busy, and father gives him no affection, but his Airedale gives to him just what he needs. Mother is spending a long winter evening alone, while father is entertaining the out-of-town buyer. She overcomes or forgets her doubts because of the friendly collie that lies before her on the living-room rug. Cousin Edna, who is not quite welcome at the relative's home where she is now living, is at least confident of the genuineness of the affection with which the family's energetic Boston pup greets her. Father, returning late at night after a long and discouraging day, is met at the door by a wagging tail and a pair of adoring eyes. Each to his needs, regardless of what they are, no matter how they vary, ready to give, asking nothing even when expecting much, stands the family dog.

Furthermore, there are none of the customary inhibitions to limit or restrain our affectional relations with the dog. Few of us are wholly free of these inhibitions in our relations with humans; often they operate to some extent even with those who are most close. We leave unsaid the word of endearment or unexpressed the physical signs of our feelings because of the inhibiting shadow of some word or aspect in our relationship. None of this is true with our domestic pets, like the dog. (We can love them, we can express our affection, and there are no inhibitionary handicaps.)

3. There is often a deep and abiding quality about the relationship between a human and a dog. One is struck repeatedly with the mellow tribute of the older person to the canine companions of his youth. Such tributes appear constantly in conversation or in autobiographies. Writes a Congressman from Iowa:

"After much begging for it, I was given a silver dollar one Saturday morning with which to buy a black collie puppy that I coveted. With the piece of silver clasped tightly in my hand, I ran all the way to town, fearing some other boy might get what I wanted. With the puppy clasped tightly in my arms, I hastened back home. I bestowed the name of Prince on the tiny creature. After that we all made so much ado over that little dog that the old dog on the place . . . died of envy and grief—or was it merely old age?

"Prince and I grew up together. We became inseparable com-

panions. I might have taken him to bed with me had my mother been less particular about sheets and pillows. I was very fond of Prince and he was fond of me. He would never play with any one else or at least not in the same way he played with me. He would growl and snap his teeth at any one who made so much as a motion of striking me. He must have thought of me as the particular lamb that he had to look after. Every morning I found him waiting for me at the door, and if I did not hasten my steps he would whine and yelp. He always greeted me by jumping almost all over me. One of his favorite tricks was to pick up a stick and dare me to take it away from him. In time I taught him to play many of my games, such as hide-and-seek and ante-over. And he taught me many of his tricks. I am still sure that I learned as much from him as he learned from me. And I am equally certain that if it had not been for Prince, I might have grown up a different kind of boy and even have been a different man."¹

4. The dog contributes to the development of many a human being the challenge of a continuing responsibility. This matter of a continuing responsibility is one of life's major experiences—sobering, exacting, maturing, character forming. Not all of us have it. Many persons go through life without it; others find it first when parenthood comes to them. This experience may come early in life, to a growing child, when a pet is consigned to his care. Walking the dog each morning and night, feeding him, finding him when lost, looking after his water supply, protecting him from the neighbor's bullying bigger dog, making his bed, if it is a female, keeping dogs away when she is in season—in these ways, children may profit early in life from a continuing experience with a personal responsibility. Thus the dog may become a very valuable factor in the training and character formation of a growing boy or girl.

5. The dog is one of the best vehicles for parents to use in training children in toilet habits. Josephine, the pup, must be house broken. Mother, father, brother, sister, are all engaged in the process. They take Josephine out; they chastise her for her making a puddle; there is constant talk about Josey's toilet habits. Small wonder, then, that little Helen presents no problem in her own habits, for she, too, joins the family circle in the training of Josephine. Here, again, self-discipline evolves as an accessory before the fact of imposing a discipline upon some one else.

6. Again, the dog is possibly the best available vehicle

¹ From *I Remember, I Remember*, by Cyrenus Cole. Proceedings, Iowa State Historical Society, 1936. pp. 20-21.

for parents to use in the sex education of children. First, the external physical differences of sex can be seen, identified, and discussed, without hesitation or inhibition on the part of either parent or child. Then certain habits peculiar to each sex may be discussed, so that sex is a difference not just in physical structure, but also in function and in ways of living. If the dog is a female, the alternation of periods has to be faced, and this becomes the medium through which various problems are discussed, including periodicity in the human female. The female may have been spayed or she may be serviced by a male. The ensuing pregnancy and birth of the pups are a demonstration of that which it is perhaps most difficult to teach the younger child. With a dog, they are demonstrated to the eye as they are told to the ear. Such physical demonstration can be made a corrective of a most effective kind of the misinformation on sex that children pick up at various times and places.

7. The dog is a satisfactory victim of personal needs for ego satisfaction and ego gratification.) If things have gone wrong, and you feel like kicking some one, there is Waldo, waiting for you. If you have been ordered about by the boss all day, you can go home and order the dog about. If mother has made you do what you did not want to, you can now work on the dog. Long observation of children's behavior with domestic animals convinces me that this is a very important function. Often the child has been the victim of commands, "directives," shouts, orders, all day long. How soul-satisfying now to take the dog for a walk and order him about! This is a most effective therapeutic procedure.

8. Akin to what has just been said is the fact that the dog satisfies the very human longing or desire for power.) The wish to dominate some one seems most fundamental. Wife, husband, child, each finds in the dog an outlet for such conflicting desires. Sometimes this demand for power finds expression in a persistent habit pattern, and the dog, in satisfying it, thereby saves some other member of the family from being its victim. Sometimes it is a sporadic need, growing out of a background of fluctuating experience. At times, it is the chronic need of a Casper Milquetoast who

finds only in the dog what he fears to seek in any other human. Here, again, the dog may serve a useful rôle in the mental hygiene of the child, training the child in the art of command, satisfying the ego in the experience of control, and draining off a resentment at being controlled by some parent or other adult.

9. A dog accustoms one to the idea of the normality of physical processes. We humans are apt to become so civilized that we forget that we are human; the conventions of life lead us to refrain from certain physical processes when we are in the company of our fellows; reference to some of them is even taboo in conversation. The net result is that there is apt to arise an unconscious conviction that these things are unusual and unnatural. This is particularly true of city folk, who lead an artificial life in many respects, often without contact with other forms of life. To live with domestic animals is to see another animal engage in the same processes you do; the effect upon the observer, and particularly the child, is to gain a net impression of the "naturalness of it all."

10. (A dog serves as an effective social aid.) By the time one has walked a dog a few months, one is sure to have increased markedly the range of one's acquaintances, even in the most impersonal city neighborhood. The genial old man stops to chat; the buxom mistress smiles, first at the dog, and then at you; the neighborhood children make friends with the dog and incidentally notice you. Finally, on the dreariest day, when you were least inclined to take him on his outing, fate obliges by having your favorite blonde happen along, and the dog obliges by making up to her, to the end that another "contact" has been made.

The child, again, is the special gainer from all this. He or she makes many contacts in the neighborhood because of the dog. It is a sure way to meet the new children in the block. And you can do them the first favor by letting them hold the leash. You can make that little girl with a turned-up nose jealous because you have a dog. You learn about Mr. Davis; he is a friendly man and likes dogs. You learn about Mr. Meyers; he barks at you if the dog nears his least favorite shrub. Mrs. Jones feeds a dog, even under war rationing.

Mrs. Bird growls at you because she hates "animals of all kinds."

11. A dog often reveals the underlying feelings in the neighborhood, and by bringing them out into the open serves a useful mental-hygiene purpose. Mr. Smith does not like you, and as a result he chases your dog. You think the Goldsteins, coming into the neighborhood, have depreciated your property, and you threaten their hound. Mr. Kline is a splendid man, and you throw his dog a bone. Even as you do it unto a man's dog, so you do it unto him. This serves often to bring the unconscious likes and dislikes of a neighborhood out into the open. Dogs do not create neighborhood feuds—they reveal them. In so doing, they may serve to heal them.

12. (A dog is an effective and continuing object of conversation in the family.) Particularly is this true because he stands mute. If relations between husband and wife are strained, the dog becomes the needed excuse for a renewal of conversation. Compliments may be paid to another member of the family through the dog. The dog serves as an excellent butt for jokes; you may poke fun at him with safety; you may show off your best humor on him. You may compose a poem about him. Also, a dog is an excellent excuse for saying certain things for the benefit of the children.

13. Finally, (a dog offers companionship.) He stays with you when you are alone. He serves as solace when you are lonely. And what excellent company he can be. You can talk to him, you can sing to him. He does not argue concerning the propriety of your remarks or the pertinence of your observations. If you sing, he will not, as a rule, embarrass you with comments on your voice, your enunciation, or the lyrical quality of your performance. A dog is a silent, yet responsive companion, a long-suffering, patient, satisfying, uncritical, seemingly appreciative, constant, faithful companion, more affectionate than you deserve and appreciative far beyond what any one could expect from a human rival.

To the lonely child and the shy adolescent, to the unhappy wife or the misunderstood husband, to men on far off military location or on distant construction jobs, innumerable dogs make their contribution to mental hygiene. And they cannot even say the words. Humans are more verbal.

CURRENT PRACTICES IN GROUP THERAPY*

GROUP THERAPY AT THE JEWISH BOARD OF GUARDIANS

S. R. SLAVSON

*Director of Group Therapy, Jewish Board of Guardians;
President, American Group Therapy Association*

IN THE development of any science or scientific practice, growth usually occurs from the general to the particular. The inductive method leads to generalizations and suggestions which, when applied in practice, require further breakdown to suit specific situations. This has been true in all scientific practices; it is equally true of psychotherapy. The general formulations as to the nature of mental dislocation and psychopathology were first applied in blanket fashion. Hypnotism and suggestion have had their day. Psychoanalysis, too, has been applied uniformly for some decades. Recently psychoanalysts have found it necessary to readapt practice to suit the treatment needs of specific clients.

Many significant contributions, though varying in essential details from the original source, stem from the teachings of Freud. The school of ego-therapy and "social therapy," also stem from the parent trunk of psychoanalysis. In the opinion of the present writer, no one method of therapy can be regarded as universally applicable to all psychiatric patients. The effectiveness of a method of treatment, with its variations, rests upon its suitable application to a particular client. Frequently it becomes necessary to combine several methods to effect results. Perhaps the greatest skill of a therapist lies in his ability to understand the client's problem, to gain insight into his character and personality—often through intuitive perception—and to select the line of treatment to which the patient will best respond. When

* Papers from the program presented at the First Annual Conference of the American Group Therapy Association, New York City, January 14 and 15, 1944.

this matching of patient and treatment is made, we can expect successful outcomes, and certainly more rapid results than when we impose a treatment procedure rigidly.

This approach, it seems to us, is not only the rational approach, but the approach through which the maximum of effectiveness will be attained. It is the approach used in all enlightened efforts. Workers in the fields of education, recreation, social work, therapy, and industry—in fact, in all fields that involve human relations—find that individualization is the primary condition for success. Blanket techniques are being systematically abandoned for the more effective and more realistic methods of individualization. Thus flexibility is a prime condition for successful work with people; it is also a prime condition for success in psychotherapy. Awareness of this has resulted in many new developments in psychotherapy in recent years, one of which is group therapy. As group therapy was employed with a variety of patients and clients, it, too, had to be modified to meet the needs of individual clients.

At the Jewish Board of Guardians, group therapy began in 1934 as "recreational therapy." Some of the clients of the Big Sister Department evidenced a need for reducing their feelings of isolation and securing social satisfaction through association with girls of their own age. The volunteers and the professional workers of that department discovered that some of the girls were unable to establish individual relationships, or that, when they did, these were on a superficial level and of little benefit. What these "little sisters" needed was to break through their emotional encapsulation, to overcome their fear of contemporaries and their distrust of adults. This seemed a primary need in the treatment of some of these girls.

One cannot overlook the fact that behind such social withdrawal, there are frequently more or less serious character malformations and other personality disturbances originating in early interferences with instinct gratifications, unmet ego needs, inadequate sense of security, and undesirable relations and experiences with people. Because of the special nature of their problems—namely, incapacity to relate to people—these girls could not derive benefit from individual

psychotherapy, in which relationship is the pivot and focus of treatment.

In order that the girls might not be threatened by the group, the program of activities consisted of trips and picnics, in which a minimum of interpersonal activity occurs. Here they had an opportunity to ignore one another or to make contact with the other members of the group at a rate and with a degree of intensity suitable for each. Refreshments were supplied by the leader, so that the girls could, if they so wished, talk to one another or hold group conversations. A group as flexible and amorphous as this can be described as having *social mobility*. Frightened and disturbed persons can utilize groups of such low pressure and need them as a transitional experience to more direct and personal relations. There were in this group of eight or nine members also one or two quite aggressive girls. They were permitted to act out their domineering pattern and experience the reaction of the others to their behavior.

After several months of this form of "social therapy," it was observed that some of the girls had not only become more social in their impulses, but also showed general improvement. This gave us the idea that more intensive group treatment ought to be tried. The general pattern of this development is now known as "activity group therapy," which has been described in some detail elsewhere¹ and need be only briefly outlined here.

Activity Group Therapy.—Eight boys or girls are grouped together in accordance with their suitability to one another. The first consideration is age. Children within an age range of between a year and a half to two years are placed together, except where social, organic, or emotional development indicates the advisability of diverging from this general rule. Extreme problems—either of a neurotic nature or in the nature of a behavior disorder, especially of an aggressive type—psychopathic personalities, and psychotics have been found unsuitable for this type of treatment.

Groups are supplied with simple arts-and-crafts materials and tools to which the members have free access and which they can use quite freely. No restrictions of any kind are

¹ See *An Introduction to Group Therapy*, by S. R. Slavson. New York: The Commonwealth Fund, 1943.

imposed at the beginning of the treatment. The children also have free access to the total environment and can utilize the room, furnishings, and other appurtenances spontaneously and in whatever manner they wish. This is a *permissive environment*. Limitations, control, and denial arise naturally as members infringe upon the rights and convenience of others, and at later stages in treatment from the therapist as well.

All meetings end with a repast of simple food, sometimes cooked. Usually it consists of milk, fruit, and cake. At table also there is complete freedom as to manners and idiosyncratic behavior. Children can eat with the group or take their share and eat by themselves in a corner. They cangulp or chew the food or throw it at their fellow members if they so desire. They can grab the victuals, stuff them into their pockets, share with the others, or try to take more than their rightful share. By their own suggestion and choice, the members of the group arrange trips to museums, parks, zoological gardens, industrial establishments, theaters, the opera, and other places that may interest them.

The purpose of these groups is to give substitute satisfactions through the free acting out of impulses, gratifying experiences, group status, recognition of achievement, and *unconditional love* and acceptance from an adult, and to help the children overcome basic character malformations, such as emasculation in boys, confused identifications in girls, feelings of impotence, and fear of expressing aggressive and hostile impulses. In such an environment and group relationship, the infantile and overprotected child can become self-reliant and act more maturely, the exploited child becomes a more autonomous and self-activating entity, while the rejected child, with the broken-down ego and low degree of self-esteem, can be built up.

The attitude of the group therapist is a permissive one. The clients who come to these groups must be convinced that he is a kindly, unretaliating, friendly, yet positive individual. The group therapist is neither domineering nor pampering, nor does he exploit the child for his own emotional needs and gratifications. The group therapists are individuals who have no love cravings or emotional drives toward chil-

dren that would tie them down and impede their growth. The children are set free to grow at their own pace through the pressure of the group and a new orientation toward environment and people.

This rôle of the worker is described as a *neutral rôle*. Neutrality must not be confounded with passivity. The worker is not always passive; though he strives to be so, he succeeds only to the degree to which his children will allow it. Some have an emotional need for him and come to him for help, consultation, and comfort on the slightest or no provocation. Other children, on the other hand, withdraw from and do not communicate with the worker in any way. The worker accepts the projections upon him by each child; this attitude we describe as neutrality. He is expected to remain outside the emotional flux of the group, so as to allow interpersonal and intra-group emotional and physical activity on the part of the children themselves. This is necessary because clients are chosen for group treatment because they need to relate to other children rather than to an adult.

After some years of practice in this type of activity group therapy, it was discovered that not all children who needed group treatment could be placed in such unrestrained, free-acting-out groups. Some needed groups of lesser *aggression density*, such as young children and neurotics. Younger children cannot be permitted to act out all their aggressiveness and exuberance, because they first need to establish self-restraint. What may be described as the *group super-ego* is as yet unformed in them. Highly neurotic children also cannot endure acting out aggressive hostility without becoming disturbed and further traumatized. Young people in middle and later adolescence, as well, do not gain much from arts and crafts in free-activity groups. Because of this no one pattern of group therapy can be applied to all clients in a clinic or agency, and we found it necessary to inaugurate other types of group that would meet the varying needs of clients.

Groups for Pre-school Children.—Small groups of children under five years of age are provided with appropriate play materials, such as toys, animals, dolls, carts, trains, blocks, clay, water, paper, and crayons, to which they have free access. The children play singly or in small groups of two

and three. Play here is almost entirely of a phantasy nature, and the young clients reveal many of their overt and hidden aggressions, resentments, hostilities, fears, and confusions. Whenever an opportunity presents itself, the therapist helps the child to make the display of his inner emotions meaningful to him.

Expression of aggressive drives is conditioned and limited, since children so young cannot use freedom constructively or therapeutically. The children, however, are made aware that their behavior and their personalities are accepted and respected. Limitations are imposed for the benefit of all concerned. It is well known that a child can accept limitations if he is secure in the love of the adult and if the latter is not abrupt and arbitrary. The children eat together at the end of each session.

Perhaps the greatest value of this treatment lies in the fact that the mothers of the clients are in treatment simultaneously in another room by another worker.¹

Activity-interview Groups for Young Children.—We have also play groups for young children up to ten years of age who are provided with play and some simple arts-and-crafts materials and tools, family dolls, clay, paints, and paper. The children also eat together. As the children act out and talk out their problems and difficulties with parents and siblings, the therapist explores these with an individual child, with several of the group, or with the entire group. The maximum membership in such groups is five; usually the number is smaller. These groups provide the children with an opportunity to live out corrective sibling relationships in a free permissive environment, where they can verbalize repressed unconscious strivings and confusions, and are helped to gain an understanding of their own mechanisms.

The content of the interviews with these children is centered around siblings and parents, anal, urethral, and genital phantasies, and preoccupations. Birth is a frequent topic for discussion. Masturbation is another subject that comes up often. Thus the child gains release in activity through play and work, and also is relieved from guilt and fears

¹ The plan of treating children and mothers in groups at the same time we have borrowed from the Brooklyn Child Guidance Center, of which Dr. Lawson G. Lowrey is the director.

concerning "prohibited" topics by which he is obsessed. The child is helped to gain insight into his mechanisms, attitudes, and values on the level of his comprehension and capacity to absorb and make inner adaptations.¹

Group Interview Therapy With Adolescents.—Another type of group found necessary in our work is with adolescent girls whose difficulties are such that they can be best reached through group discussion with its resultant insights. In these groups, no materials of any kind are provided. The girls eat together only occasionally. The conversations here are of the same nature as in individual interviews, but the presence of others with similar problems gives each support and they are thus able to bring forward latent and repressed material. The group interviews yield clarification of and release from problems and develop friendships among the members which they sometimes continue outside of the group. The group case-worker here helps each member to break through anxieties, gain understanding of her problems, and develop attitudes toward parents, siblings, and the world generally.

Occasional questioning, direct and indirect discussion, and interpretation help each member of the group to find release from traumatic emotional disturbance. The therapist also helps to expand the world of reality not only emotionally and intellectually, but also through trips and visits suitable for adolescent girls. The theater, museums, art exhibits, dances and parties with boys are among these.²

Transitional Groups.—Still another type of group treatment is represented in our "transitional" groups. These groups are formed for boys and girls whose treatment is at the point of termination or whose problems are so light that all they need is to overcome some hesitancy or shyness in social adjustment. Transitional groups usually meet in settlement houses or neighborhood centers at the same time

¹ This work has been described by Betty Gabriel in "An Experiment in Group Treatment" (*American Journal of Orthopsychiatry*, Vol. 9, pp. 146-69, January, 1939) and by Leon Lucas in "Treatment of Young Children in a Group" (*The News Letter of the American Association of Psychiatric Social Workers*, Vol. 13, pp. 59-65, Winter, 1943-44).

² See Slavson, *op. cit.*, pp. 321-326. See also "Group Treatment of Six Adolescent Girls," by Betty Gabriel. *The News Letter of the American Association of Psychiatric Social Workers*, Vol. 13, pp. 65-72, Winter, 1943-44.

that other activities are going on. At first, however, they are somewhat protected against this larger community and are exposed to it slowly until they are absorbed individually or as a group into the activities of the building. These groups are not supplied with any arts-and-crafts materials, nor are they given foods. The parental rôle played by the worker or the set-up is eliminated.

Mothers' Groups.—A more recent development at the Jewish Board of Guardians is the treatment group for mothers. The mother is usually the source of the child's problem, and her continued rejection, infantilization, or exploitation of him frequently presents a serious handicap to his treatment. It is, therefore, necessary to change this relationship between the mother and her offspring before treatment can become possible or effective. This being the newest development in our work, it will be necessary for us to explore further these areas and perhaps learn from the experiences of agencies and clinics in which groups for mothers are being conducted. Some of the criteria we now use include social and intellectual equality and similarity of the age, sex, and problems of the children, as well as some personality qualities of the mothers themselves, among them an ability to relate to other persons. The actual treatment process is similar to that for adolescents and is described more fully in Mrs. Kolodney's paper in this symposium.

CONCLUSION

In conclusion, one general principle can be drawn from our description of the Group Therapy Department of the Jewish Board of Guardians. By and large there are two types of treatment that we employ—treatment *through* a group and treatment *in* a group,¹ and a combination of the two. In activity group therapy, in transitional groups, and in pre-school groups, the group itself, the derivative satisfactions and relationships among the persons involved, are the sources of therapy. No insight is given by the therapist. Whatever insight a child requires concerning his problem is given by a case-worker or is a spontaneous outgrowth of his under-

¹ See "Group Therapy," by S. R. Slavson. *MENTAL HYGIENE*, Vol. 24, pp. 36-49, January, 1940.

standing of his past and present feelings and attitudes, which are often verbalized in the group or to an individual worker (derivative insight). On the other hand, the adolescent and mother groups constitute treatment of individuals *in a group*. Although the presence of other persons helps the individual, he is the focus of the worker's attention. Play groups or activity-interview groups are a combination of treatment *through* a group and treatment *in a group*.

It may be helpful to return to the opening statement in this paper—namely, that just as no other type of psychotherapy can be used in blanket fashion, so group therapy, one of the forms of psychotherapy, cannot be applied universally without regard to the clients' needs. It is necessary to suit the method of group therapy to the type of problem in the individual whom we are attempting to help.

AN ADVENTURE IN GROUP THERAPY IN A FAMILY-AGENCY SETTING *

HELEN C. WHITE

District Secretary, Community Service Society, New York City

THE Group-Case-work Project—so-called because of the joint participation of group and case-workers in the conduct of it—came into being as the result of a joint interest of the faculty members of the Group Work Department of the New York School of Social Work and the Gramercy District case-workers of the Community Service Society. With the group contingent, there was a desire to formulate and to try out concepts of practice and philosophy through a laboratory method of approach. For the case-workers, there was the challenge of broadening horizons in the treatment of children.

In many family service agencies, there has been a growing interest through the years in direct observation of and contact with children. Aware that in familial scenes fraught with conflict and with the clash of personalities, treatment of the troubled child may depend essentially upon treatment

* Recognition should be given to Dr. Anne Lambert, a former member of the Gramercy District staff, for her contribution to the project described here.

of the parent; aware, too, that contact with and interpretation of the needs of the child to the adults who influence his life in the home, the school, and at play is a way of lessening environmental strains, and thus of easing inner tensions, case-workers have learned also that the child in and of himself may have problems. With the acquisition of psychiatric knowledge and through counseling with psychiatrists, they have become more mindful of intra-familial dynamics and their interplay, and therefore are more consciously reaching out to young people. They are sustaining direct contact with them. And they are recognizing that in so doing they are more nearly fulfilling the purpose that they have long envisaged as the intrinsic reason for their professional being—namely, to discover and bring into play the factors that tend to prevent the breakdown of family life and to conserve its strengths.

Here, then, was a way of observing, of discovering the needs of the individual, and of treating those needs in part through a group approach. The use of the phrase "in part" is intentional, since emphasis was placed on the integration of treatment by group leader and case-worker through an exchange of observation, factual content, points of view, and goals. The experimental nature of the method was emphasized; no specific pattern was to be followed, nor was the plan as it developed to be considered as a model for other similar undertakings. Simply defined, it was a way to help children and to evaluate skills and procedures in the attempt.

Our objectives were twofold: first, to afford the individual an opportunity in a protected group setting for growth in socialization; second, through observation of his behavior, his reaction to other members of the group and to the leader, his response of interest or lack of it, to make use of diagnostic clues for furthering an understanding of his needs and how to treat them.

There has long been general acceptance of the values to be derived from activity in clubs, settlements, and other specialized organizations. Indeed, such groups are so much in demand as to cause them to be weighted on the side of too many members, with resulting loss to the individual. On the other hand, many young people are denied this opportunity

for an enrichment of their lives through a broadening of human relationships. There are reasons for this—the insufficient number of such resources, their inaccessibility to certain neighborhoods, opposition and prejudice on the part of parents with cultural backgrounds different from those of their children, and so on.

There is the child, too, who is unable to adjust to or to derive enjoyment from such activities—the very shy child, the emotionally unstable child, and the child who acts out his difficulty in aggressive and hostile behavior. Frequently it happens that such children, steered into group participation, find only unhappiness in the experience and become unacceptable to their fellows. These are the children who are labeled "misfits" by overburdened group leaders. These are the children who may yearn for an association with others, who are hurt by their incapacity to make a place for themselves, and who seek to find that place through ways not tolerated by society. Sensitive to such children's needs, psychiatrist, case-worker, and group worker, by providing differential treatment, may open for them new paths to social living.

It was in behalf of such children that this experiment was put into effect. We saw it as a step toward the forming of more normal alignments. We saw it as a way of helping the child potentially capable of constructive relationships, whose problems, at the moment stemming from inner strains, environmental limitations, or both, were interfering with or arresting his social growth. We believed that the office of a family agency might provide a suitable theater for the undertaking. With it both parents and children were familiar, and because of previous experience with case-workers, there would be at least a feeling of confidence, if not a full understanding of the group's purpose.

There were values, we felt, in limiting the membership to eight children, and to those who were not manifesting extreme problems in behavior. A room was selected adequate in space. Equipment of games, arts and crafts, and the needed tools was provided. The costs of refreshments were met by the agency. Two weekly meetings were planned for, one to be held at the office, with a program of games, manual work,

story-telling, and special parties; the other to take the form of an excursion into the community.

The group started in late April of 1942 and was terminated in October, 1943. Three students from the New York School of Social Work assumed the rôle of leader at three different time periods—the first for three and a half months, the second for approximately four months, the third for the rest of the time.

The children invited to the group had had some previous contact with the case-workers, but in varying degrees and on varying levels of treatment. The families of all but one child were known well to the worker. Summaries of the familial scene and historic background, together with a personality picture of the child, were prepared by the case-worker. Evaluations were made at subsequent periods.

Group leader and case-workers held conferences as the need arose. An advisory committee, with personnel from the Group and Case-work Departments of the New York School of Social Work, district case-workers, a settlement-house director, a psychiatrist, and the group leader, held regular meetings for the purpose of formulating concepts with respect to methods and philosophy.

Five girls, with an age range of from eleven to thirteen years—with one exception, that of Frances, fourteen years old, who was mentally retarded—were invited to the group. Three more of similar age range were added within a short time after its inception. Of the eight, two withdrew after a relatively short period. Six girls continued with well-sustained attendance until July, 1943, when, with the approval of the advisory committee, Frances was dropped.

Psychometric findings were not available on all of the girls, but reports from schools and general observation revealed two as of superior intelligence (Nancy and Lydia), three with an I.Q. range of from 81 to 101 (Sylvia, Toni, and Maria), and one definitely retarded (Frances). All of the girls came from deprived familial settings, with economic strains present in five. Marital friction figured as a serious problem in the households of three, reaching at times a high pitch of violence. Rejection by one or both parents was evident in the case of four of the girls; the air was rife with

sibling rivalry for three. Broken homes—with the absence of either father or mother through death, commitment to a state hospital, or separation—had served as a factor that already had left damaging scars on the personality structure of the children.

One girl, Lydia, had attended camp prior to the group organization and had made a happy adjustment to it. Nancy and Frances had never had camp experience; Sylvia, having gone, had only negative reactions to it; Maria and Toni had formerly shown acute anxiety toward and rejection of it.

Nancy and Toni were without doubt the most emotionally unadjusted of the six children, with the result that Nancy later was placed under direct psychiatric treatment; in behalf of Toni, case-worker and psychiatrist were in consultation. The two girls who at previous times had been members of a group had not maintained contact. All, however, with the possible exception of Frances, were felt to offer real potentialities for growth in socialization, but to need help.

The rôle of the group leader was essentially that of an "accepting mother," interested in giving attention to each individual, but also in keeping the group as a whole in mind. Freedom of choice as to activity, alone or in participation with others, and freedom of expression were left with the child. The leader was more passive than in the usual group. She made use of authority only when it became necessary to meet the demands of reality or when a situation gave promise of going destructively beyond control. She recognized that her rôle was a changing one, with a different meaning for each child. It may be said that this rôle did not differ substantially from that of the normal group leader. It was rather a difference in degree.

Through the creation of an atmosphere of warmth and friendliness, through the provision of a positive experience, either in working alone or in sharing with others, it was hoped that the child might be helped "to reduce his asocial behavior for the reason that he would have no further use for it."

The experiment may be said to have passed through five stages, the first three conducted by School of Social Work students. During the first period, the girls had the experi-

ence of becoming acquainted with the leader and with one another. They were distinctly on "party behavior" and for a time too insecure to assume the initiative, to voice objections, or to offer suggestions, but obviously they were entranced by this new opportunity to "do things and go places." The rôle of the leader was essentially enabling. Standing aside or in the background, she encouraged the children to plan for themselves, but was ready to offer suggestions when these were needed or desired, and to become a participant in the fun. She was aware of the educational theme as implicit, of herself as a channel through which "bits" of interpretation could be offered, through which by subtle suggestion the child might learn to relate more comfortably to the others, to express the "self" more freely, to develop more richly, and to discover through her own imagination a way to creative living.

Trips were made on double-decker buses, to museums, the Planetarium, and the Zoo; picnics were held at parks and at Coney Island. Refreshments were planned and served by the members. A budget, not too set, but within limits as to amount, was worked out by the girls for short periods of time.

Indications of group consciousness began to emerge. Phrases such as "our club," "our room," "our dishes" were voiced. A party for "the ladies in the office" was spontaneously planned and carried out. In July one member suggested that the group have a name, and it was christened "The Good Times Club."

During the following four months' period, with a new student leader, clouds gathered, the storm broke. Individual feeling and self-assertion came to the fore. There was more open rebellion against the leader, more rivalry for her attention, a need to make her pay. Hostility was directed against associates, with sadistic behavior toward Frances in particular. Closer relationships between individuals began to take form.

The leader continued to maintain an "accepting" rôle. The group's reaction was felt to be a healthful, normal expression of individuals who, becoming acquainted with one another and secure with their leader, were able to voice differences. When these gave promise of becoming destructive, they were met by the leader. Out of the experience,

group entity seemed to take form, and the fact that conflicts could be met with acceptance gave subtle evidence of constructive meaning to the method.

During the third period (January to June, 1943) more stress was placed upon the content of program and with gradual enlargement it was geared to the individual's social way of performance. More of an attempt was made to draw the group together in common objectives. A "Guest Day" was instituted; there were trips to a settlement house and use of the settlement stage for dramatics. There was limited discussion of cultural as well as developmental problems. There was consideration and interpretation of new program suggestions and of the use of authority when such interpretations could be intellectually understood and emotionally accepted. The group leader's attitude was one of personal guidance, encouraging, but firm. She was not so much the mother as an adult whom the children could accept and admire as a person, and enjoy as a companion and as a co-actor in activities. Thus she was able to further the children's participation, and eventually to find a natural way of excluding herself at certain points. She was present to help when needed and to insist on the carrying out of decisions when once they were made.

The fourth stage covered a month spent at camp. Five girls were accompanied by the leader, who, although acting as cabin counselor, was drawn into other activities which served to separate her from the children during parts of the day. This, then, constituted the first step in a transitional experience from the protected atmosphere of the club room to participation in a larger, more natural, and more detached setting.

The fifth stage consisted of a return to the district, with subsequent preparation of the members, individually and together, for termination of the group, their introduction into a neighborhood settlement, and a meeting with their mothers to interpret the change and to gain their permission for and interest in the new alignment. As was anticipated, disbandment of the group, the giving up of the leader, was painful for these girls, with responses that found outlet in different forms of expression. It is perhaps encouraging to note, however, that of the five girls, three have formed a

good contact with the settlement. One other, Nancy, is physically and probably emotionally too ill to attend at present, but has expressed the desire to do so later. Sylvia is reported by her mother as having found a happy outlet through many friends and neighborhood activities.

As case-workers, we are more critical of our contribution to this project than of that of the group leader. For the latter's performance there has been universal enthusiasm, aware though all may be of the needed refinement of skills, acquisition of knowledge, and clarification of thinking as to function and goals.

In retrospect, we see the gaps in coördination of treatment, the failure at times to recognize quickly enough what the child was trying to express, the problems she was revealing in her acting out. Thus, when Maria talked much of her father, of his constant complaints against her, but of his demands that she alone wait on him, when she spoke cautiously of accompanying him on excursions with his paramour, and stated with disdain that she did not like "the Italian young lady," when in play-acting she was the seductive woman who draws her lover into long and passionate kisses, we realize that we could have been more alert to her need, and to what was happening in her world of phantasy and in its reality. Psychiatric treatment should have been sought more promptly for Toni, a disturbed, unhappy child; and personal contacts should have been maintained more regularly with the very intelligent Lydia, who, rejected by her father and patterning her behavior after her dominating mother, met both at club and at camp with obstacles to the achievement of her desire and with hurt feelings when associates, sometimes lightly, but more often with malice, dismissed her good suggestions.

We offer no defense for our lapses, but we recognize the challenge to better methods, mindful that when there was close collaboration between case-worker and group worker and alertness to diagnostic clues, there were accrued values to the individual under treatment. The awareness of a shift in the emphasis of direct contact between case-worker and child was something also to be evaluated, for the need of the worker by these young people was not a uniform one. Perhaps, too, there was some confusion for the children in

the rôles of the two workers. Obviously, also, with the relationship between child and leader so important to treatment, the frequent changes were a basic weakness.

Time will not permit here of an evaluation of the success and failure of this project, nor, indeed, are we yet ready to attempt it. In general, we feel confident that the experience has proved growth-producing in varying degrees to each one of the children. Such gains are subtle; their lasting value is not yet to be measured. It may be significant to note that for the two cases taken to psychiatrists for consultation, a continuation of the group contact was urged.

Do those of you who have read *A Tree Grows in Brooklyn* recall the counsel given by Grandmother Rommelly to her children? "To look at everything always as though you were seeing it either for the first or last time. Thus is your time on earth filled with glory." That, we believe, reflects the attitude brought to this experiment, new to us, and the attitude that we shall bring to others like it, which may follow. For this project here described, many questions still remain to be answered. Whether or not similar undertakings will be continued beyond another year is as yet undecided; whether or not this form of venture into treatment lies strictly within the function of a family service agency is as yet undetermined. In essence, it is enough for the moment, for us who participated in it, to believe that it opens up new paths to learning and that it widens the scope of our ways of helping troubled people in a so troubled world. And in such helping there need be no rigid "either-or" of method, no final "yes" or "no."

BOYS HOUSE—THE USE OF A GROUP FOR OBSERVATION AND TREATMENT

MARTIN GULA

Boys Bureau, Community Service Society, New York City

ONE of the tasks confronting professional social work is that of discovering new treatment techniques for reaching children, adolescents, and adults who have not responded to traditional methods of case-work, group work, and psychiatry. Each field has recognized its own limitations and

has sought help from others. As a result, new treatment approaches have evolved.

This meeting represents a phase in the development of one new approach: group therapy. Different agencies have developed in different ways their use of groups for therapy. Basic, however, seems to be the assumption that the maladjustment of many persons has isolated them from help from normal groups or from individualized treatment. Also basic is the assumption that treatment of a person's social relationships by a group may affect individual emotional attitudes just as successfully as treatment of a person's individual emotional attitudes by case-work may affect group social relationships.¹

Group therapy has approached these isolated individuals through the use of a sheltered, selected, contemporary group, guided by an adult trained in psychiatric concepts. In this atmosphere an adolescent, for example, can release feeling, gain acceptance by contemporaries, and begin developing constructive emotional attitudes around an adult.

The Boys House Project.—For thirteen years the Boys Bureau of the Community Service Society has offered case-work services to homeless and unattached boys of from sixteen to twenty-one years of age. It has long recognized the need for a special living facility for purposes of observation, study, diagnosis, and treatment.

To meet this need, in January, 1943, Boys House was established as a part of the Boys Bureau. It is a group residence located at 88 Fourth Avenue, New York City. Its purpose was to study the boy in a group and living situation, to facilitate case-work diagnosis and planning. Since treatment aspects were inescapable, some experimentation was anticipated in using the group for treatment as a supplement to case-work.

The number of residents at the house was limited, at first, to thirteen. The staff living at the house consisted of the director, his wife, a cook, and a housemaid. The director is responsible for administering the house, gathering observa-

¹ See "Experimental Group Treatment of Maladjusted School Children," by H. M. Shulman in *Probation and Parole Progress*, edited by Marjorie Bell. (1941 Yearbook of the National Probation Association.) New York: The National Probation Association, 1941. p. 345.

tional material, and functioning as the trained adult in the selected group. He has had several years of clinical and generalized case-work experience as well as several years of group work.

In the house, each boy has his own room. Three meals a day are served at a common family table. The house provides "big muscle" materials such as saws, hammers, wood, boxing gloves, wrestling mats, volley ball, pool table, and the use of a local swimming pool. Other materials are clay, oil, water colors, plaster of Paris, linoleum, carving tools, table games, radio, piano, and jazz and classical records. More social media are informal co-ed parties, skating and bicycle trips, group dinner discussions, generalized horseplay, and "bull sessions."

Residents for Boys House are selected by the case-workers of the Boys Bureau. Before referring a boy, the worker, the house director, and, in special situations, the psychiatrist consider the boy's needs and the emotional resources of the house group. The ages of the boys range, as we have stated, from sixteen to twenty-one; two-thirds of the boys have been seventeen years of age or younger.

Boys come from New York City, from children's institutions, and from out of town. Various races, religions, and geographical and environmental backgrounds are represented.

In preliminary interviews with the case-worker, the boy is told about the house and its program. If he decides to become a resident, he comes alone or with his case-worker. He is shown through the house and introduced to the staff and boys. He is given a room and linens, and is oriented to the informal manner in which the house operates. From that point on, the boy's individual use of the group depends, largely, on his own emotional needs and development.

In this project, the following practices have been followed:

1. The *case-worker* has the responsibility for the referring of cases, for diagnosis, and for continued treatment.
2. The *group* usually contains a nucleus of "normal" boys who give a constructive tone to group interaction. The group of boys is small enough to personalize relationships. Chronological age and emo-

tional development are not too varied. Psychotic, seriously delinquent, or actively homosexual boys are not accepted for the group.

3. The *director* uses case-work orientation for observation and recording of behavior, but not for discussion or interpretation with the boy. He is prepared for the group's symbolic use of him as a parent, teacher, contemporary, or other person. He may suggest areas of activity, but does not assume a directing rôle in activities.

What is the emotional atmosphere that a boy finds when he comes to live at Boys House? In the words of our psychiatric consultant, the house "provides a family setting without the usual demands and pressures that a family exerts." During the early diagnostic period, boys can sleep all morning if they wish. They are roused only if they request it. They can use their rooms according to their own psychological needs. One boy decorates for hours; another boy dumps clothes and gadgets everywhere. They do not have to come to meals. Boys who come in after midnight are not lectured.

There are, however, group rules in the house. For example, one "spoiled" boy was late for six successive meals. Invariably, he demanded courses that had already been completed. The reaction and irritation of the group expressed itself in a "rule" If a late comer arrives after first helpings have been served, he sits and waits for the second serving. If he arrives after that, he sits and waits for dessert.

There are definite limits on permissiveness beyond which a boy cannot go, primarily when he tends to hurt others or himself emotionally or physically. No pressure in the house is exerted on a boy's use of time. He can seek out the adult, the group, or avoid the group and the adult. All courses are possible and occur every day. The director is usually neutral, but he may steer boys together or apart for therapeutic reasons. He limits destructive group trends and strengthens constructive group leadership. Constructive tone and socialized direction tend to emanate (1) directly from leaders in the group or (2) indirectly through a boy's identification with adults in the house. Frequently, the director's wife is

used symbolically by these youngsters to evolve their emotional development. Often a boy's emotional identification may shift from one person to another within a day.

Boys may bring in a girl or a boy friend, or relatives. Some immature boys have brought in their own "society" when they entered the house. The house has been host to one dog, two alley cats, thirty-five hop-toads, and one six-inch guinea pig.

Group interaction is concentrated at the evening meal and the evening group activities. Throughout the day, most of the boys are at work or at school, and group interaction is diluted and minimized.

For ten days after a boy comes into the house, his behavior is observed and recorded for the case-worker each day, the records covering such areas as physical mobilization; eating habits; emotional use of adults, boys, and girls; emotional fluctuations; reaction to frustration; use of time, sleep, and money; response to school, work, and material possessions; and the boy's version of himself. When craft, drama, or art productions show symbolic interpretative value, a description of the work is included in the boy's record. In addition to the individual records, a group record is available, weekly, to all case-workers at the bureau, to familiarize them with the nature of the group in the house, the number of the boys, their races, ages, group activities, dominant relationships, emotional tones, and conflicts, and suggestions as to delinquent or constructive trends.

During the boy's third week in the house, the case-worker, the supervisor, the psychiatric consultant, and the director confer on the diagnostic and treatment developments in terms of the case-worker's approach and the group influence. During the boy's sixth week, a second conference determines whether the diagnostic use of the group has been completed—whether extended stay is needed for further diagnosis or for treatment by the group. The average length of stay has been six weeks. Boys who stay longer than six weeks pay a realistic room-and-board charge. A small number of "treatment" boys have stayed for substantially longer periods. The psychiatric consultant, in addition to functioning at the point of reference to the house and at the three- and six-week conferences, is used by the case-workers

for continuing consultation and occasionally for direct treatment of boys, and by the director in clarifying problems that arise in the group situation.

Evaluation of Boys House Project.—This paper is being presented too soon after the inception of the project to incorporate the findings of planned evaluative research. Nevertheless, after a year of experience with eighty-five boys, certain definite impressions may be presented.

Boys Bureau case-workers feel, definitely, that their initial work with boys is facilitated because:

1. The select group and living situation facilitates diagnosis with uncommunicative, dull, or protective boys.
2. Diagnosis is more accurate with delinquent, disturbed, or sophisticated boys than it would be through interviews alone.
3. Observing a boy in a group reveals areas such as homosexuality, delinquency, or psychopathology more readily than interviewing.
4. Differential diagnosis can be employed in various ways, such as clarifying comparison between "psychometric" defectiveness and social intelligence; or determining the physical or the psychological basis for illness.

Case-workers' impressions concerning treatment have been that:

1. Immature, dependent, and non-communicative boys frequently use the release and security of the group and the staff before they can use interview therapy.
2. Immature boys who lack early emotional satisfactions with parents tend to create a family in the group and use the adults and the group symbolically. One boy constantly refers to the director and his wife as "Pater" and "Mater."
3. There is reduction of tension and anxiety through work with plastic and other materials, and symbolic release and expression.
4. The non-punitive rôle of the trained adult allows

boys to express more freely negative, "prohibited" feelings. For example, a boy who at first set fires and threw needle darts at other boys gradually worked through to a constructive, satisfying relationship to adults and a coöperative attitude toward other boys.

5. The verbally aggressive, egocentric boy reacts strongly to group disapproval and frequently has modified his personal drive to secure group approval.

6. Temper outbursts, defiance, bullying, lying, and cheating symptoms usually are reduced as security in the groups grows.

7. The tempo of case-work movement has been accelerated in many cases based on the findings or movement occurring in the group situation.

A word might be added in comparison of the group living situation and the special group in group therapy. The special group, meeting only for several hours weekly, provides a child with a trained adult, a select group, and a permissive social situation for a few hours and then returns the child probably to a destructive family and street group for the next six days. In the Boys House project, the boy is provided with the concentrated, select group experience for several hours each day. He leaves concentrated group activity, but still remains in a "select" situation in which the various persons and personality elements are known and can be manipulated. The "known" situation is constant and controlled throughout the week and is not interrupted by a return to unknown destructive situations. When boys are ready to leave Boys House, the return to the more demanding outside world is made gradually and planfully.

In closing, it may be said that the Boys Bureau findings, after the first year, though still tentative, are sufficiently stimulating to encourage a comparison and a sharing of the use of the group in Boys House with other agencies. The daily work shows enough gains and growth in the boys to encourage further experimentation in the second year of operation. This will be based on an expanded program of twenty-four boys, additional staff, and increased use of crafts, art, informal drama, and music. Extended periods will be

used for more boys for specific treatment in the group. It is believed that this second year of experimentation will further increase understanding and facility in the use of a group for therapeutic purposes.

TREATMENT OF MOTHERS IN GROUPS AS A SUPPLEMENT TO CHILD PSYCHOTHERAPY

ETTA KOLODNEY

Senior Case-worker, Jewish Board of Guardians, New York

THIS paper on the subject of group treatment for mothers presents the point of view of The Committee on Group Treatment Projects at the Jewish Board of Guardians. The committee functions under the chairmanship of the director of group therapy and includes a consultant psychiatrist, the supervisor of case-work, and a number of psychiatric case-workers and supervisors who have charge of treatment groups.

Work with mothers in groups is a new venture at the Jewish Board of Guardians. It was introduced in 1942¹ in an effort to discover whether some mothers can be helped more easily with their problems and those of their children under group treatment than is possible in individual therapy. In spite of comparatively brief experience with the method, sufficient evidence has emerged to confirm the validity of group treatment for mothers. After careful study by some of our workers and psychiatrists, the Jewish Board of Guardians is now embarked on a definite program of such treatment. Various methods are employed experimentally in order to ascertain the best type of treatment for mothers with different psychological syndromes and varying difficulties with their children. Several theoretic concepts have been evolved from our work which are employed tentatively as a basis for selection, grouping, and treatment.

Aim of Group Treatment of Mothers.—The aim in treatment of mothers in groups at our agency is to change their

¹ See "Collective Psychotherapy of Mothers of Emotionally Disturbed Children," by Fanny Amster. *American Journal of Orthopsychiatry*, Vol. 14, pp. 44-52, January, 1944.

attitudes toward their children. There are some who believe that an effort should be made at direct treatment, so as to change the personalities of the mothers themselves. After considerable deliberation, there was almost unanimous agreement that since the function of this agency is to treat children, treatment of parents and siblings must be geared to the needs of our own clients, and the aim should be treatment of the child-parent relationship. While it is to be expected that some changes in the characters of some of the mothers will inevitably result, this should not be the aim of treatment.¹ In this respect there is a distinct difference between our project and those of other clinics and social-service agencies, where direct treatment of mothers is the practice. Recently, however, a group has been organized for direct psychotherapy of mothers in our agency as an experiment.

Functions of Worker.—The function of the worker or therapist has been defined as one of molding the group into a unit, so that it can operate with one common objective. The worker gives the group stability and balance. The latter is especially important where excessive resentment toward any one of the mothers is activated. The worker has to steer clear of serious disturbance and not allow the group reactions to go beyond what any one of the mothers can carry emotionally. She must continually bear in mind the treatment limitations of each mother and the capacity of each to take treatment. It is important to hold in check expression of deep-seated problems and feelings of inadequacies too early in treatment. The client must first be mobilized to withstand the group's reaction and criticism. In many instances the mothers themselves act as therapists to one another, as activators or instigators, neutralizers, and supportive egos,² but the leader must be constantly aware of the direction that

¹ Since the above was written, we have found that the limiting of group discussions to child-parent relations has proved unproductive. The mothers have repeatedly returned to the same problems, have oscillated in their attitudes, reversed decisions, and changed their minds. We found it necessary to help the mothers to see themselves as persons in this relation and to enter into areas of their own personality problems. It must be noted that the members of the group have displayed a need for deeper insight which the therapist has helped them verbalize.

² See *An Introduction to Group Therapy*, by S. R. Slavson. New York: The Commonwealth Fund, 1943. pp. 119 and 153.

the discussions are taking. The primary group code¹ must apply here as in any group set-up—i.e., there must be a common denominator which will enable the mothers to function as a unit.

It is very important that the worker be at all times aware of any hostility directed at a member of the group who may not be able to defend herself. Supplementary group treatment by individual interviews for a specific mother may be necessary. In line with this function of the worker is her ability to recognize at what point to bring in interpretation and on how deep a level. Timing is of the utmost importance. She must recognize the stage of emotional receptivity to insight into problems, and she should use specific material brought out by the group as a basis for elaboration and release of feeling, and for helping the clients to understand and formulate such concepts as aggression, compliance, love hunger, expectations of parents and their frustrations, and the child's growing-up process with its aberrations.

There was some disagreement among the members of the Committee on Group Treatment Projects on the question of the worker's defeat by the group. A repetition of serious disagreement between her and the group may not be desirable. The worker has to exercise tact in avoiding conflict with the clients. In this respect also there exists a distinct contrast between this method of group treatment of mothers and direct therapy. The worker does not employ the transference relationship and does not work through with each client her hostility toward the worker.

Dynamics of Treatment.—In group treatment, more than in individual treatment, satisfactions are essential. The process in group treatment must lead the client to see her rôle as a mother and her relationship to her children. The experience in the group leads to "socialization" of the mothers, helps them to face their aggression and to discover that friendliness, frankness, and affection for and toward one another is not a threat. The group process itself leads the members to discover that there is such a thing as mutual acceptance and tolerance. Their relationship to one another and to the worker have components similar to those in the

¹ *Ibid.*, p. 153.

interpersonal relationship in individual therapy—*i.e.*, sibling rivalry, hostility, efforts to please, and so on. They react strongly to group approval and disapproval and show resultant changes in their everyday handling of their children. One of the positive factors in group treatment is the recognition by mothers that their problems are universal, which tends to make them less defensive and resistive.

The following extract is taken from the record of a meeting, to illustrate some of the points that we have made:

"Mrs. E said she agreed that mothers will have problems, but she wishes that mothers had gotten instructions and help along emotional and spiritual lines at the birth of their children in the way pediatricians have given them directions along physical lines. Mrs. P agreed and said there are places where one can get this kind of understanding. . . . Mrs. E said it was such a hard job. Mrs. E was very friendly to-day. She did not have her usual hard, bitter, and sad expression on her face. At this meeting she looked squarely at every one and smiled much more freely.

"Mrs. G took on a rather dominant rôle in relation to Mrs. E particularly, but both Mrs. P and Mrs. Z came to Mrs. E's rescue.

"Mrs. E complains that her son demands too much attention from her without regard that she has two other children and a home to look after. . . .

"Mrs. G wondered why she shouldn't give him the attention he needs. There ensued a good deal of intense, but friendly discussion. Mrs. E said she didn't know how to divide her time any more because each one of the children demands so much from her. Mrs. G insisted that a mother had to decide which was more important. . . . Mrs. E said that her son does not need help with his school work. He has a good head on his shoulders.

"To-day Mrs. E did not make him out the bad, spiteful child that she described before. She seemed more sympathetic, but was at a loss. Mrs. Z said that maybe he was jealous of the attention she was giving the younger child. Mrs. E nodded and said, 'Sure, he says he's jealous and maybe he's right.' Mrs. G and Mrs. P discussed between themselves how a mother can work out her day's schedule so that it is possible to give each child what is needed. Mrs. E interrupted and said Mrs. G really didn't know how difficult it was because she has only one child.

"Mrs. G laughed and said the women here don't know what problems she has. She has to keep her relatives from yielding to her son's demands for attention and preventing him from being the center of things. She herself used to think his antics cute, but when he became a problem at school and could not get along with the teachers and children, she had to admit that there was something wrong, even though she resisted it for a long time. Here she turned to the worker and said that is where the Jewish Board of Guardians came in and 'thank God for them.' She used to agree with her son's complaints against teachers

and other children, but now she knows better. Mrs. Z smilingly and knowingly said she, too, used to be like that. Mrs. G said, you know it's much easier to settle matters by giving in to your child, but it certainly didn't help him, as she can now see. Now she reasons things out with him and lets him take responsibility for his acts."

Diffuse discussion on a free-association basis, as against confining the group to a consideration of their children's problems only, is a point that needs further observation. Some workers feel that dilution in content is helpful at times, to relieve stress, and frequently brings the members closer to one another. It was felt that the group might be less threatened if the leader used opportunities on occasion to dilute the content. However, the members of one of our groups complained because the "meeting" was too diffuse and no problems were settled. They came for a specific purpose, they said, and wanted to concentrate on the problems at hand.

What happens to the atmosphere and the "psychological complexion" of the group when some mothers are absent or when new ones are introduced, is another matter to consider. Do such changes also change the treatment situation, in view of the fact that a new group composition is effected either through absences or additions? The group atmosphere is greatly altered when the persons absent or added are strong and play an important rôle in the discussions. These "central" persons or indigenous leaders have a particularly telling effect upon all the others. This situation is more or less inevitable. There will always be some members absent, and it is necessary at times to add new ones. This does change the complexion and the configuration of the group psychologically, for new forces are created to which the members have to respond.

Such reorganization in the group complex may be undesirable when it occurs too early in the life of the group. A group has to evolve a degree of stability and oneness before it can withstand alterations in its composition. The interpersonal relationships need to be strong enough to stand the change before support by some members is removed or the group is invaded by newcomers. In later stages in the group's life such changes may be desirable because new and different stimuli for self-revelation and discussion are added.

Some mothers may feel constrained by the presence of a specific person and become more communicative when this person is absent.

Tentative Criteria for the Selection and Grouping of Mothers.—It is the feeling at our agency that group treatment should never be used as an economy measure. Rather clients, whether children or adults, should be assigned to groups because their specific treatment needs are such that they can benefit more or solely through group therapy. Some of the mothers that fall in this category are:

1. Mothers who have a desire and a need to be with others for social satisfaction, but who, because of personality difficulties, cannot participate in the ordinary neighborhood or social groups.
2. Mothers whose sole preoccupation is with their children and family and who need to dilute this intensity of interest. Such mothers need to find some self-fulfillment and some interests outside of the immediate family circle. As their drives toward the children are reduced, the latter can grow more freely and normally. Treatment groups are essential here as a transition to wider social participation.
3. Mothers who develop too many interests outside the home as an escape from their difficulties. Such mothers are often helped through therapy groups to face their situation more realistically.
4. Women who, because of limitations, need a less intensive therapeutic experience than individual treatment offers. Through the group such women have an experience of acceptance; they gain relief through sharing with other people and feel that the problems that press upon them are more or less universal. For intellectually limited and emotionally blocked clients, this type of experience is more real and meaningful than individual treatment.
5. Mothers who are resistive to individual treatment, but who can communicate problems in the presence of others with similar difficulties.
6. Mothers who cannot, for a variety of reasons, enter into a close relation with a therapist, but whose

attitude affects the treatment of their children. Such mothers should be referred to groups in the hope that they will have some influence upon the mothers' attitudes.

Even mothers who suffer from severe pathology can be included as long as they do have capacity to relate to people. They can benefit in the handling of some of their attitudes toward their children just as they would in individual therapy, where the objective also would not be treatment of the pathological condition.

The intelligence of the mothers should be as far as possible on the same level, so that all may understand the content of the discussions.

Mothers are being selected for group therapy on the basis of similarity in age and sex of the children under treatment. It would appear, however, that chronological age is not the sole factor. The emotional development of the children may be a better criterion. A division of mothers on the basis of the sex of the children, however, is desirable since boys and girls present different types of difficulty.

It has been agreed that clinical diagnosis of the child clients alone is not a valid basis for the grouping of mothers. The behavior of the child is more significant than the specific clinical diagnosis.

In actual experience, the workers in our agency had to become oriented to the meaning and the value of group treatment for mothers, since it is a new project. Although group therapy for children has been carried on for ten years, treatment of mothers is a recent development. In the past it was considered either as a means of mobilizing gains in individual treatment or as a means for implementing treatment with mothers who were extremely resistive. In short, up to the present time, the mothers who have been drawn into group treatment have been selected from either end of the treatment situation.

We are aware of the fact that it is not possible to be too definite about criteria in any field of endeavor. Much must be left to the judgment of the referring worker or the psychiatrist. Elements in the personalities of clients are often too intangible for specific description. We found it rather neces-

sary to sensitize the case-workers, intake workers, and psychiatrists to the values and possibilities of group treatment. It is upon this sensitivity, as well as upon objective criteria, that we must rely in choosing clients and evolving treatment plans. Some mothers are being treated individually as well as in groups, while the treatment needs of others can be met by group therapy exclusively.

We are still in an experimental stage and are testing out various methods, as well as combinations of treatment plans. As the work continues, we hope to get greater clarification, particularly as regards the choice of treatment procedures to suit the specific needs of various clients in the agency.

THE RORSCHACH TEST AS AN AID IN SELECTING CLIENTS FOR GROUP THERAPY AND EVALUATING PROGRESS

MIRIAM G. SIEGEL

Senior Psychologist, Jewish Board of Guardians, New York

AS A psychologist at the Jewish Board of Guardians, my main contact with the Group Therapy Department has been in conjunction with the use of the Rorschach test. This test consists of a series of ten ink blots which are offered to the subject one at a time. Through his responses, he projects a picture of his underlying personality structure. Such projective techniques are found to be more valid than the paper-and-pencil type of questionnaire, since there are no manifestly correct or incorrect responses. The subject does not reflect through this test his knowledge of socially acceptable traits, but rather reveals his own unique personality pattern.

The test has considerable value as a supplementary diagnostic tool. It cannot expose the genesis of personality disorders, but it does reveal character structure. In our agency it has been widely used as an additional diagnostic instrument and as an aid in formulating treatment plans.

In connection with group therapy, there seem to be three areas in which the test has been particularly useful. One of these is in the selection of clientele; another, in determining the status of a case during treatment and in making sugges-

tions for continued group therapy or for reference to individual therapy. In regard to the first use—that is, the selection of clientele—the psychologist depends on criteria established by the Group Therapy Department of the Jewish Board of Guardians. In general terms, these are children who have a basic need to be part of the group, otherwise described as "social hunger."¹ Children with social deviations arising from severe character malformations and malignant forms of neuroses and behavior disorders are at present considered unsuitable for group therapy by the director of that department. Nevertheless, a permissive environment that tolerates aggression is helpful in those cases in which difficulties in social relationships arise, almost without regard to the specific pathology involved. Both the timid and withdrawn and the overaggressive child are benefited by this type of group experience.

Of particular importance are the dynamic tendencies that seem to yield to group therapy. These are a need for constructive relationships, for ego strengthening, and for constructive identification with adults; tendencies toward emasculation and feminine identification in boys; and an interest in arts and crafts. We find that such tendencies can often be recognized through the Rorschach just as certain clinical entities can be differentiated. Since the test reveals the intrinsic personality structure underlying observable behavior, such a judgment about a case can sometimes be reached before it is clinically manifested.

I should like to cite as my first case a boy whose Rorschach indicated a need for group therapy. This ten-and-a-half-year-old boy, the youngest of three siblings, was referred for conduct difficulties in the home, of an aggressive, annoying, irritating nature. The father was for the most part absent from the home, and the household consisted of female adults. The mother had very high standards of moral conduct and polite manners, to which the boy was forced to adhere. He was not accepted by boys of his own age because of his provocative, attention-getting behavior. With adults he was extremely ingratiating and eager for praise and approbation. The Rorschach test revealed a very frightened boy who was

¹ See *An Introduction to Group Therapy*, by S. R. Slavson. New York: The Commonwealth Fund, 1943. p. 15.

exhibitionistic and too verbal, and who tried hard to give the impression of being "nice," educated, conforming, and polite. His strong aggressive drives were entirely repressed, though they were manifested in his phantasy. He exhibited some feminine traits, and there was some suspicion of homosexual activities. His verbosity, slyness, constant need to cover up, and too ready adaptability to any therapeutic measures made individual therapy very difficult. Group therapy was suggested by the Rorschach examiner.

The case-worker persuaded the boy to enter a "club," where he is being carried as a coöperative case—that is, he is being seen simultaneously for weekly interviews by a case-worker. In a recent report from group therapy, he was described as having leadership potentialities. He has displayed aggression in the group and has established favorable relationships with other boys and with the group therapist. In terms of his personality dynamics, the boy seems to respond well to group therapy. Other diagnostic tools, including the psychiatric, have verified the original Rorschach recommendation.

The two other cases I should like to report are those in which the Rorschach was used primarily to help determine the status of a case during treatment and to help fix the point when termination of treatment might be advisable. Some of these repeat Rorschachs were administered in connection with a research study now being conducted at the agency on the prognostic validity of the test.

One is a boy, the youngest of four siblings, who was referred to the agency four and one-half years ago when he was eight years old. During his contact with the agency, three Rorschachs were administered. The original reference described a compliant youngster who was well behaved at home and elsewhere, but who engaged in considerable phantasy at school. In the street, however, he was cruel, wild, and aggressive. This behavior he never manifested at home or in school. The mother was a domineering woman who crushed her husband and children. The psychometric examination indicated average intelligence and a severe reading disability which had an emotional basis. A Rorschach, given six months after the case was opened, revealed destructive phantasies, considerable inverted aggression, marked egocentricity, and

emotional detachment. The diagnostic impression was one of schizoid potentialities.

Another Rorschach test, administered nine months later, showed the boy even further removed from reality. Outer aggression and hostility were more repressed, with a possibility of less overt misbehavior, but an even more destructive phantasy life. The diagnosis of schizoid personality was verified, though it seemed too early to anticipate a schizophrenic process. During this period the boy continued to see his case-worker on a weekly basis and remedial instruction was given him. Nevertheless, there was very little movement in the case, and the worker found him inaccessible to individual therapy.

A year and a half after the original reference of the case, the case-worker closed it and transferred it to group therapy. The boy attended meetings regularly. At first he was shy and withdrawn, but later he entered into a good relationship with the other members and the group therapist. He was aggressive in a self-assertive rather than in a hostile fashion. The impression of the group therapist a year and a half after the client joined the group was that he was more relaxed, free, and outgoing. A Rorschach was requested to help determine whether he should continue in the group.

The third Rorschach showed that the boy had given up some of his earlier indulgence in excessive phantasy and instead participated in various environmental experiences in which he could express his aggressive drives without fear. The earlier sadistic phantasies were considerably diminished and his responses to the test showed some indications of anxiety and caution. Although his personality structure remained predominantly schizoid, there were indications of a developing neurosis and a better capacity to respond to his environment. He felt some anxiety about destructive tendencies he had previously manifested quite freely. The prognosis was less guarded and broadened group contacts were suggested. The Rorschach impressions were confirmed by a psychiatrist, who described the boy as still emotionally detached and inhibited, but distinctly improved.

The third case to be described is also one in which three Rorschachs were administered for diagnostic reasons, as well as to determine improvement. Here the Rorschach

as well as the clinical diagnosis was extremely confusing, and group therapy had the added function of serving as a diagnostic medium.

The client was a girl, the middle of five siblings, referred for treatment when she was eight years old. The original reference stated that she laughed hysterically in the classroom and showed marked irritability at home. She was exhibitionistic, frequently indulged in sex play with boys, and claimed that she wanted to become a policewoman when she grew up. She was sexually fixated on her father and antagonistic to her mother, and had strong competitive feelings against her brothers, who were favored by the mother. The family was living on a marginal income, the mother was "neurasthenic," and there was marked friction in the home.

The girl was seen on a supportive basis for about a year and then the case was closed because of the mother's lack of coöperation. However, she was again referred a year later at the mother's request because of an exacerbation of symptoms.

A psychometric examination indicated average intelligence. The first Rorschach, administered four years after the original reference of the case, indicated an infantile, evasive child, but no diagnostic conclusion could be reached. The girl had a definite character malformation, which could not be explained by a temporary disturbance. Several months later she was referred to group therapy. The opportunity to be part of a group helps such clients relate more satisfactorily to girls and to overcome sibling rivalry. Our patient was extremely jealous of one of her younger sisters.

Another Rorschach administered a few months after her membership in a therapy group revealed the girl as very resistive, calculating, extremely evasive, in search of excitement. The test showed the client as a sadistic individual, stubborn, defiant, with an underlying insecurity which was concealed by teasing and aloofness. She had a marked contempt for males and tended toward sex delinquency.

After the first six meetings the group therapist reported that she had definitely become a part of the group. She seemed to have acquired more self-confidence and was accepted by the others, who followed her leadership. The therapist felt that the girl would improve when she became

more realistic in her ambitions, when she began to make friends with other girls on a girl-to-girl basis, and when she derived a satisfaction from activities like cooking and sewing. The client was very consistent in her attendance at all meetings and began to take a more feminine interest in her dress. Her capacity to relate was very superficial, but she developed an effective relationship with the case-worker, and showed more freedom in interviews.

The group furnished the case-worker with a barometer with which to measure the effects of her treatment, since the girl was living out the case-work therapy in the group.

A third Rorschach was administered three years after the first one. The girl showed a willingness to conform and adjust in a more socially acceptable manner. These socially acceptable tendencies, however, seemed like a superficial layer of her personality. She was still self-centered and aggressive, and her confusion with respect to masculine and feminine rôles persisted.

A psychiatric interview at this time confirmed the degree of improvement the girl had attained, but indicated that she had a very narcissistic character structure, predominantly neurotic. She was still considered seriously disturbed, though the group had alleviated some of her difficulties. She was still confused, since she felt that all kindness came from the male, yet in the group she found women who could be kind to her. She is still in the group and though she remains an essentially dependent child, she is striving toward maturity.

In this case the three Rorschachs were extremely valuable in evaluating the client's response to group therapy. They reflected the difficulties of the case, recognized the personality structure underlying the clinical observations, added concrete data, and were generally helpful in giving direction to the treatment plans.

AN EXPERIMENT IN "PREVENTIVE TESTING" IN THE KINDERGARTEN

FRED BROWN, PH.D.

*Chief Psychologist, Child Guidance Clinic, Minneapolis Public Schools;
Supervisor, Kindergarten Binet Testing Program*

EDUCATORS are becoming increasingly aware of the responsibilities of education for the mental health of the pupil. It is now fairly well recognized that the laws of learning function best in a tension-free atmosphere, and that the most effective pedagogy often falls short of its mark when the object of the teaching process is rendered inaccessible by intra-psychic conflicts that sap available energy and create inner distractions. The school child is functionally educable only when he stays within the teacher's sphere of influence. If he is tense, worried, and insecure in the classroom situation, if it symbolizes a threat to his ego, he tends to escape by withdrawing into a realm of phantasy, in which satisfactions not readily obtainable in the external environment are easily achieved. Or he may strive for pseudo-adequacy by means of dominative-aggressive behavior patterns directed against other members of the group.

It is now well known that many forms of maladjustment involving pupil behavior and personality integration have their roots in frustrative experiences during the early years of the child's school life. Mental hygienists have long stressed the need for early recognition and prevention of conflict-creating circumstances, but they have been somewhat less clear in suggesting clear-cut techniques for the implementation of this highly desirable objective. Before embarking upon a description of the program utilized in the Minneapolis Public Schools to meet this need,¹ it might be well to point

¹ Teachers and principals who would like a more detailed description of the program outlined here and suggestions for implementing it in their schools may obtain this information by writing to the author.

out certain persistent obstacles to the meaningful appreciation of individual differences by the teacher.

The chief obstacle, as it appears to us, lies in the intrinsic and unavoidable organization of the "class." The teacher is accustomed to dealing with groups, and as a consequence of this her perception of the individual pupil becomes blurred. When we appreciate the awesome complexity of the individual personality and realize that there are literally thousands of adjectives that may be used to describe personality traits, it becomes increasingly important to note that most school children are classified into extremely crude categories, based upon random observations. The term "crude" is used advisedly, for many of these observations are influenced by biases, resemblances, and contrasts.

Again, like most individuals who attempt to rate personality traits, the teacher is susceptible to the "halo effect." This means that she is likely to rate the child who is high in scholarship as similarly high in comprehension, application, and dependability. Or she may rate the vivacious-verbal child as equally competent intellectually and socially.

The difficulty of arriving at a dependable and meaningful picture of the child may be inferred from the comments often found on cumulative record cards. Such descriptive statements as, "Shy, withdrawn, doesn't make friends readily," "Doesn't try hard enough," and so forth, offer no clue to the probable motives for such behavior manifestations. In many cases these comments and labels are repeated year after year, indicating that little has been done to modify the child's behavior.

Practices such as these may indicate that the teacher has observed a salient facet of the child's personality, but has remained ignorant of the total child. This dependence upon crude estimates is partly due also to the lack of an objective, controlled situation against which each child's reactions could be observed and recorded. In such conditions there might be a diminution of the tendency to remain contented with stock phrases; instead, dynamic, in-the-situation descriptions would incite to further questioning, followed by a desire to do something about undesirable traits.

Of recent years the "mental test" has been widely used to give educators a more reliable estimate of the pupil's capacity

for academic work. Unfortunately, the *real* value of testing is frequently overlooked and its dynamic possibilities have been discarded in favor of the illusory reality of a numerical index. Furthermore, in most cases testing at the elementary-school level, especially below the third grade, is dependent upon the use of group tests, whose validity at those levels is dubious. Even if this were not so, group-test results tell us very little about the individual child, and in some cases are quite misleading. They contribute very little to the picture of the total child as a functioning entity.

In 1935 we instituted an experiment in "preventive testing" in the kindergartens of the Minneapolis public-school system. This program differed from others in the fact that bald I.Q.'s were not given to teachers on the mistaken assumption that such indices had the same meaning for all people. In our program *the teacher tests her own pupils*, thereby acquiring a first-hand picture of the complex process whereby such scores are obtained. Teachers are given a course of lectures and demonstrations in the use of the Stanford-Binet scale,¹ up to and including the nine-year level. Teacher testers are then required to administer a minimum of seventy-five tests, interspersed with at least three periods of observations and guidance by a trained psychologist. All tests are carefully checked for arithmetical and scoring errors, and the teacher is certified as qualified to test her pupils and enter their scores on the cumulative record card when administration of the test is judged to be faultless, and when scoring does not deviate more than three I.Q. points from that of the psychologist. Statistical studies based upon later retests by trained psychologists have shown that the reliabilities of teacher-obtained I.Q.'s are as high as those found between the test results of psychologists.

This plan has the following advantages:

1. The I.Q. assumes newer and broader meaning for the teacher when she observes how children of presumably similar intellectual endowment, as shown by the I.Q. alone, may nevertheless vary greatly in their pattern of successes and failures on the test. She notes that a comparison of two pupils with I.Q.'s of 110 will reveal that one child passes

¹ Before 1937 we used the 1916 revision of the scale. Since then almost 75 per cent of our examiners have been certified on the 1937 revision of the scale.

tests of rote memory and motor coördination (drawing a diamond, stringing beads, and so on) and fails on tests of comprehension and reasoning, while the other child excels on tests of reasoning and vocabulary and fails in number and memory items. She may also note that the first child fails some tests below his chronological-age level and has a lower basal age, whereas the second child has a higher basal age and passes several tests two or three years above his chronological-age level. The significance of such patterns of success and failure may be related to the child's total mental functioning, a significant factor frequently overlooked by I.Q. addicts.

2. Accustomed as the teacher is to making qualitative evaluations of her pupils in the classroom situation, her observations in the intimate, controlled observation setting of the testing situation may throw new light upon the child's modes of response and his personality make-up. She observes that the verbal child, who gives an impression of alertness and intelligence in the classroom, does poorly when he is required to deal with specific problems posed by the examination, which cannot be evaded or faked by profuse and ingratiating verbalization. On the other hand, the timid, shy, and withdrawing child may often give surprising evidence of potentialities far beyond the teacher's expectations. She notes that the slow-reacting pupil is not necessarily dull, nor is the rapid-fire child necessarily bright.

Indications of an unsatisfactory home environment may be revealed in the responses of children to such an item as, "What is the thing for you to do when you have broken something that belongs to somebody else?" Replies such as "Hide the pieces," "Run away," "Get a spanking," or, "Go to jail," are sometimes encountered. The child with perfectionistic tendencies may spend minutes in his efforts to copy a diamond figure, drawing and erasing until the paper is worn through. Egocentric tendencies come to the surface among those children who frequently interrupt the test to talk about their own interests and activities. Pictures of animals are given a strongly personal coloring in the children's descriptions of them. Comprehension items, such as, "What is the thing for you to do if you see on your way to school that you are in danger of being late?" may elicit

denials or release a long narrative of personal experiences. Such spontaneous declarations sometimes give the teacher insight into the child's social contacts and offer valuable clues to his social environment.

We have noted that the insecure child continues to compete with others and strives for the teacher's approbation by such frequent remarks as, "Is that right?" "Did Johnnie get that right?" "Am I better than Alice?" Or he may overestimate his abilities by prefacing his replies with such remarks as, "This is easy," or, "This is baby stuff." Such comments acquire deeper meaning when tests approached in this manner are flatly failed or when rationalizations appear in the presence of slightly more difficult tests. A common remark noted in such instances is, "I used to know that, but I forgot it." The varieties of response that emerge in the testing situation are virtually endless and contribute rich material to the otherwise static I.Q.

3. The I.Q. and mental-age scores become more valuable when seen in the context of the child's responses. Taken by themselves, their value is not to be underestimated. In one case the teacher remarked that one of her pupils was "very helpful and seemed to know a lot about animals. He seemed to be above average in intelligence and was well-behaved and courteous." The test revealed a child with an I.Q. of 160! Conversely, children with mental ages of less than six years are not likely to be ready for reading experiences in the first grade and will benefit by being retained in the kindergarten for another term. The program aims to protect mentally inferior children from discouraging competition with their superiors and to accelerate brilliant pupils who might otherwise lose their spontaneity by being forced to keep pace with comparatively mediocre pupils.

The kindergarten Binet testing program provides a workable plan for the implementation of mental-hygiene principles at an early period in the pupil's school life by making it possible for the teacher to arrive at a more realistic evaluation of his intellectual and social potentialities. The artificial dichotomy between intellect and emotion is avoided when the teacher is given an opportunity to observe how these two functions of the personality interact. For the first time in her experience, she deals with an *individual* rather than with a

member of a group. Her observational notes and inspection of the test record give her a practical working basis for further investigation, which will sometimes include a conference with the parents.

Moreover, her observation of the child in the classroom will become more sharply focused. In certain cases these observations will point to the advisability of referring a child for clinical service long before such reference is forced by extreme conditions.

In some cases the I.Q. will be entered upon the cumulative record card with a question mark after it, clearly implying that the test result may not be a fair estimate of the child's ability. This alone discourages blind acceptance of the I.Q. as an infallible measure of intelligence and eliminates some of the obloquy that has descended upon that much-maligned index.

Finally, the testing program removes the emphasis from *intelligence* testing and shifts it to *intelligent* testing.

PREDICTION OF BEHAVIOR OF CIVILIAN DELINQUENTS IN THE ARMED FORCES

CAPTAIN ALEXANDER J. N. SCHNEIDER, M.C., A.U.S.

LIEUTENANT CYRUS W. LAGRONE, JR., N.M.B., A.U.S.

ELEANOR T. GLUECK, ED.D.

Research Criminologist, Harvard Law School

SHELDON GLUECK, LL.M., PH.D.

Professor of Criminal Law and Criminology, Harvard Law School

A UNIQUE opportunity has recently been presented to determine the practicability of the Glueck method of predicting the behavior of delinquents and criminals during and after various forms of peno-correctional treatment, by testing one of their series of tables, published in their latest book, *Criminal Careers in Retrospect*.¹ This table deals with the prediction of the behavior of civilian delinquents in the armed forces.

In the present war-mobilization program, the problem of predicting adjustment to army life has become a particularly important one. In the first place, the army has not been committed to the policy of inducting all men who are able to meet its physical standards. The task, therefore, of weeding out potential misfits (delinquents included) has become the concern of induction stations, reception centers, and special-training centers. Also, after the army established its various rehabilitation centers, the problem of predicting subsequent delinquency was an ever-present one, for one of the functions of these centers is the selection of those individuals, from among their population of general prisoners,² who are capable of being returned to the army without getting into further conflict with military law.

¹ New York: The Commonwealth Fund, 1943.

² The term "general prisoner" refers to individuals who have been tried and convicted by a general court-martial for having violated one or more of the Articles of War. As a rule, offenders in the army are not tried by a general court-martial for their first offense unless the offense is of a serious nature. As

CIVILIAN DELINQUENTS IN THE ARMED FORCES 457

The need, therefore, for some kind of instrumentality that can be used as an aid in predicting delinquency in the armed forces has become rather widespread. This need has been accentuated by virtue of a number of characteristics of delinquents and potential delinquents. Psychopaths, for example, present a particularly difficult problem, for as a group they seem especially talented in making a favorable impression upon people, oftentimes even in spite of a history of continued misconduct, as William H. Dunn has pointed out:

The psychopath is not an individual who is disposed to frankness and honesty about his past history of difficulties with his environment. In fact, he will be inclined to gloss over unpleasant, but important, episodes. Furthermore, the psychopath tends to act out his conflicts and frequently will not show evidence of symptoms that are often helpful to the examiner in diagnosing the neuroses and psychoses. There should be no great problem with those showing organic inferiority with physical stigmata or mental defect. The physical signs will be obvious and those with mental defect are soon discovered under our system and either suitably placed or discharged for military ineptness. But the psychopath, whom we have tried to present in this article as a problem, is frequently a fine physical specimen with a good intelligence as uncovered by ordinary test procedures who feels that the army offers various desirable possibilities—economic independence from families; escape from their repeated failures in civil life; and the satisfaction of a desire to play soldier. Consequently, they try for, and too often succeed, in making a favorable first impression.¹

It was the practical difficulty involved in the problem of predicting future delinquency in the army that suggested to one of the present writers the possibility of using some of the data relating to the prediction of delinquency which had been compiled by Sheldon and Eleanor Glueck, as an aid in determining the disposition of army delinquents now confined in rehabilitation centers. In his letter to the Gluecks requesting information as to whether they had developed tables for the prediction of delinquency in the army, the Gluecks, whose latest book, *Criminal Careers in Retrospect*, had not yet been published, recognized a valuable opportunity to test their table, "Predicting Behavior of

a group among army delinquents, therefore, those sent to rehabilitation centers tend somewhat to be those whose delinquency is either of a more serious or of a more chronic nature—the latter type being, perhaps, the more common.

¹ "The Psychopath in the Armed Forces," by William H. Dunn. *Psychiatry*, Vol. IV, May, 1941. p. 257.

Civilian Offenders in the Armed Forces."¹ As a consequence, arrangement² was made for securing the necessary information relative to the five predictive factors entering into the Glueck table on 200 soldiers who had been delinquents in civilian life and who were in confinement at a rehabilitation center for having committed military offenses. Before describing the results of this collaborative effort, it would be well to review the development of the prediction method by the Gluecks.

II

Since 1930, with the publication of their first book, *500 Criminal Careers*,³ Sheldon and Eleanor Glueck have been evolving a series of experimental prediction tables on the basis of which it has been thought that judges, parole boards, and others charged with the administration of criminal justice would be able to determine, in advance of conviction or release on parole, the chances of reformability of a particular offender and the kind of peno-correctional treatment to which he would be most likely to respond.

In connection with *500 Criminal Careers* (Chapter 18), a table was constructed from which (if it were validated) might be foretold the behavior of young-adult criminals, not only on parole from a reformatory, but also during a five-year span following the expiration of the parole period. In *Five Hundred Delinquent Women*⁴ (Chapter 17), a similar table was built up for female offenders who had served a term in a reformatory. Likewise, in *One Thousand Juvenile Delinquents*,⁵ dealing with offenders who had passed through a juvenile court and clinic, a prediction table was constructed (Chapter 11) indicating the likelihood of successful or unsuc-

¹ Table 50, page 277, *Criminal Careers in Retrospect*.

² This arrangement was made with the express consent of the late Colonel Roy D. Halloran of the Office of the Surgeon General, War Department, who on July 21, 1943, wrote to the Gluecks as follows: "I am very much interested in the proposal which you outlined and feel that there may be a good opportunity through the work of Captain Schneider to test out the usefulness of the Prediction Tables which you have developed. We shall be happy to have Captain Schneider carry out this research and I shall write him to that effect."

³ New York: Alfred A. Knopf, 1930.

⁴ New York: Alfred A. Knopf, 1934.

⁵ Cambridge, Mass.: Harvard University Press, 1934.

CIVILIAN DELINQUENTS IN THE ARMED FORCES 459

cessful responses of youthful offenders to whatever treatment the court and associated agencies provided.

In subsequent researches the Gluecks extended the scope of their prediction tables. For example, in *Later Criminal Careers*¹—a volume covering a second five-year follow-up of the men originally reported on in *500 Criminal Careers*—a prediction table was presented (Chapter 12) indicating the probable behavior of reformatory inmates during a ten-year span following release from the institution. In *Juvenile Delinquents Grown Up*,² which reported the further behavior of the delinquents previously studied throughout a fifteen-year span—*i.e.*, ten years beyond the original five covered in *One Thousand Juvenile Delinquents*—a substantial elaboration of the predictive technique was made (Chapters 19 and 20). It now became possible to develop not only a prognostic instrument covering the probable behavior of delinquents over a fifteen-year period after their appearance in and disposition by a juvenile court, but also *during* the various types of peno-correctional treatment to which they were likely to be subjected in the course of their criminal careers—namely, probation, probation with suspended sentence, parole, industrial and correctional schools, reformatories, prisons, jails, and even the armed forces.

The line of research described has now, in the Gluecks's latest publication, *Criminal Careers in Retrospect*, been extended even further, permitting of the prediction of the probable responses of offenders to any of the existing forms of peno-correctional treatment *at various age levels*. In Section III of this book³ many illustrations are given of the practical application of these more refined predictive tables.

As a result of these researches (assuming, of course, the validation of all these prognostic tables), it is possible for a judge or other peno-correctional authority to determine in advance, at any given point in the career of a former juvenile delinquent or adult offender, first, what the likelihood is of his rehabilitation altogether; second, which type

¹ New York: The Commonwealth Fund, 1937.

² New York: The Commonwealth Fund, 1940.

³ P. 213 *et seq.*

of treatment promises the most success in his case; and third, at what age level he is most likely to respond satisfactorily to such treatment. Therefore, the validation of any of these tables by checking them against other series of cases becomes of the utmost importance.

III

A word by way of explanation of the tables in question. A Glueck prediction table represents, in organized and summary form, the relationship between the status of offenders in respect to certain factors in their make-up and background, on the one hand, and their behavior on the other. As in the case of actuarial tables used by insurance companies in predicting approximate life spans, the probabilities as to the future behavior of any series of delinquents and criminals are drawn from experience with other past cases that have similar characteristics.

Naturally, the factors that enter into the construction of any particular prediction table have to be selected from among those traits and characteristics of the family and personal background of the offenders that happen to have been included within the scope of the research from which the table is developed. There are undoubtedly other factors of higher prognostic value than those actually employed in the Glueck tables, but their discovery remains for future researches.¹

Although it is not essential for those who apply a prediction table to master the details of its construction, some readers may wish to have this information and it is, therefore, given in an appendix to this article, pages 474-75.

IV

Will the Glueck prediction tables give reliable results when actually applied to cases not employed in their construction? Upon the answer to this crucial question depends the practicability of such predictive instruments in the admin-

¹ The Gluecks are at present engaged in a research in which several hundred factors in the make-up and background of offenders are being reviewed. From among these they will undoubtedly discover factors—or combinations of factors—more highly predictive than those already established in their various researches.

CIVILIAN DELINQUENTS IN THE ARMED FORCES 461

istration of criminal justice and in related fields. The Gluecks have been extremely cautious about recommending the use of their prediction tables until such time as they have had an opportunity to check them against other series of cases. An important phase of a research into the causes, treatment, and prevention of juvenile delinquency in which they are at present engaged is the validation of all the tables developed in *Juvenile Delinquents Grown Up*.¹ This is being done by working out the prediction scores on each one of 500 delinquent boys at present under investigation and providing for a check-up on their subsequent behavior, both during and after the various forms of peno-correctional treatment to which they may be subjected in the coming years. The expected outcomes in terms of predicted behavior, which are now being determined statistically, will later be checked against the actual outcomes in these cases as determined by intensive follow-up investigation. The carrying out of this validation will require several years. The Gluecks hope to have a similar opportunity to check all the prediction tables recently published in *Criminal Careers in Retrospect*.

In the meantime, however, there has developed the opportunity already mentioned to test the usefulness of one of the Glueck tables—that dealing with the probable behavior of former civilian offenders during service in the armed forces. The group upon which the test was made consisted, as we have said, of 200 army general prisoners who had been delinquent in civilian life prior to their entrance into the army and who were confined at a rehabilitation center for having committed offenses while in the army.

It so happens that the Gluecks had prepared, in connec-

¹ Prediction of Behavior During Fifteen Years Following Handling by a Juvenile Court (Table 32, page 142).

Prediction of Behavior During Probation (Table 70, page 203).

Prediction of Behavior During Probation with Suspended Sentence (Table 72, page 205).

Prediction of Behavior During Parole (Table 74, page 207).

Prediction of Behavior in Industrial and Correctional Schools (Table 76, page 209).

Prediction of Behavior in Reformatories (Table 78, page 210).

Prediction of Behavior in Prisons (Table 80, page 211).

Prediction of Behavior in Jails and Houses of Correction (Table 82, page 212).

Prediction of Behavior in the Armed Forces (Table 84, page 214).

tion with both *Juvenile Delinquents Grown Up* and *Criminal Careers in Retrospect*, tables predicting the behavior in the armed forces of each of two series of offenders. This was possible because they had found that a considerable proportion of each of the two series of offenders had actually served in the armed forces (prior to the present war) and that many of them had not committed military offenses. For example, of those former juvenile delinquents reported in *Juvenile Delinquents Grown Up* who were in the armed forces at one time or another during the fifteen-year span that followed their contact with a juvenile court, 51 per cent had not committed military offenses during the first five years of this fifteen-year span; 60.4 per cent during the second five-year span; and 63.6 per cent during the third five-year span.¹ Of the offenders reported in *Criminal Careers in Retrospect* who served in the armed forces at one time or another during the fifteen-year span following their release from a reformatory, 48 per cent did not commit military offenses. Breaking this finding down into age levels revealed that 39.7 per cent of those who were in the military services during the ages of seventeen to twenty-one years did not commit offenses under the military régime; during the age span twenty-two to twenty-six, 61.3 per cent behaved well; in the age span twenty-seven to thirty-one, 66.7 per cent behaved well.²

It becomes of the utmost importance, therefore, rightly to determine, at the point of induction, which men among those who were offenders in civilian life should be kept from military service and which should be inducted; for according to the delinquents studied in the Glueck researches, at least one in two of their two series of delinquents actually did not commit military offenses.³

Information as to the behavior of civilian offenders in the armed forces on the basis of whose histories the original prediction table was constructed was available through the finger-print files of the Massachusetts Department of Public

¹ See *Juvenile Delinquents Grown Up*, p. 163.

² See *Criminal Careers in Retrospect*, pp. 152-53.

³ Data obtained on an unselected group of army general prisoners confined at a rehabilitation center showed that 67 per cent had been arrested in civilian life for felonies or misdemeanors other than traffic violations or both.

CIVILIAN DELINQUENTS IN THE ARMED FORCES 463

Safety, the prints having been in turn cleared through the Adjutant-General's Office of the army¹ and through the Identification Section of the navy. This was supplemented by data from the United States disciplinary barracks and the United States naval prisons.

The prediction table developed in connection with *Juvenile Delinquents Grown Up*² has to do with the behavior of former juvenile delinquents in the armed forces *during peace time*; but the table that the Gluecks developed in connection with their newest volume, *Criminal Careers in Retrospect*, fortunately deals largely with the behavior of former offenders (either juvenile or adult) in the armed forces *during war time*, because most of the cases from which the prediction table was constructed³ had been in the armed forces during World War I.⁴ This table is presented here in modified form. (See Table I.)

TABLE I—GLUECK TABLE PREDICTING BEHAVIOR OF CIVILIAN DELINQUENTS
IN ARMED FORCES

Prediction score	Chances of success (non-commission of military offenses)	Chances of failure (commission of military offenses)	Total chances
Under 180.....	8	2	10
180-190	5½	4½	10
190-220	3½	6½	10
220 and over.....	3	7	10

The five factors that entered into this table, with their sub-categories and prediction scores,⁵ are as follows:

1. *Education of parents*

- (37.1) Both without formal education
- (66.7) One or both had had at least common-school education

2. *Intelligence of offender*

- (29.3) Normal or superior
- (44.0) Dull, border line, or feeble-minded

3. *Age at first delinquency*

- (21.4) Seventeen and older
- (41.3) Eleven through sixteen
- (66.7) Under eleven

¹ Since then, the finger-print files of this office have been merged with the files of the F.B.I.

² Table 84, p. 214.

³ Table 50, p. 277, *Criminal Careers in Retrospect*.

⁴ This is true of all but 19 of the 131 cases on which the table was constructed.

⁵ See Appendix, pp. 474-75, for explanation as to how the scores were derived.

4. *Age began work*
 - (31.1) Under fifteen
 - (47.3) Fifteen and over
5. *Industrial skill*¹
 - (0.0) Skilled
 - (34.0) Semi-skilled
 - (49.4) Unskilled

It should be particularly stressed that the data concerning the five predictive factors on the 200 soldiers studied in the rehabilitation center were gathered without access to the Glueck prediction table, since *Criminal Careers in Retrospect* was not yet in print. The 200 cases were carefully chosen for completeness of data from a group of approximately 500. The investigator who compiled the data was given only the five factors on which it was necessary for the Gluecks to have information in order to work out the scores and to determine the chances of delinquency and non-delinquency of the 200 men in the armed forces. The Gluecks, in turn, knew nothing about the cases on which the informa-

¹ Some explanation of the last three of these factors and the criteria governing their determination should be noted. The factor *Age at first delinquency* is not confined to age at first arrest, but refers to age at first persistent signs of a developing criminal career, including any misbehavior for which a youth might have been arrested. The fact that he did not come to the attention of the police meant only that the police were not active or that the offender knew how to protect himself from detection. The stealing of candy or fruit or small articles from the "5 & 10" would certainly be included if this were the beginning of a pattern of misbehavior. If one or two isolated events of this nature had occurred, they would be disregarded.

The factor *Age at which began work* includes full-time and part-time work, but does not include helping a father or other relative after school. The emphasis is on paid work, either part-time or full-time, which truly represented the beginning of a wage-earning career. Occasional Saturday work or occasional work after school would not be considered. In other words, the age at first employment represents the point at which the boy began to contribute consistently toward his own or his family's support.

In regard to *Industrial skill*, this refers to the highest degree of skill attained by the offender during his work history. The *unskilled worker* is one who does any kind of rough work to which he can be sent without any training whatever. Mere strength of hand or keenness of eye, untutored through any course of apprenticeship or training, serves for him. The *semi-skilled worker* uses tools and processes that require learning. He cannot take up the work unless he has had a period of experience under guidance or of study. The processes, however, are not greatly complicated and the period of training is likely to be short—three days to three months, perhaps. The *skilled worker* uses tools and processes that are usable only by one who has given a long period of time, perhaps at least a year, to the acquiring of the skill.

CIVILIAN DELINQUENTS IN THE ARMED FORCES 465

tion on the predictive factors was being gathered, since they did not have access to the comprehensive case histories prepared at the rehabilitation center. Determination of the practicability of the Glueck prediction table hinged, therefore, solely on the accurate gathering of the necessary information on the five factors and on the purely mechanical computation of the prediction scores.

The question to which this inquiry was directed may be stated as follows: *In what proportion of the 200 cases would it have been possible to determine, at the point of induction, merely by using the Glueck prediction table alone, without any other data, that these men would cause trouble in the army and, therefore, should not have been accepted for army service?*

When these five factors on each of the 200 soldiers had been assembled and sent to the Gluecks, they scored each case.¹ An illustration of the method of scoring might be helpful at this point. For example, in the case of John Doe,²

¹ See Appendix, pp. 474-75, for details.

² In order that the reader may have some knowledge not only of the five factors used in the prediction score, but also of some of the related conditions that entered into John Doe's development, a brief summary of his psychiatric case history is here included.

The conditions under which John Doe grew up were those of an underprivileged child. His parents were divorced when he was two or three years of age, and he was immediately committed to the care of a children's aid society. John knew very little about either of his parents for they practically never visited him. However, he did know that his father had been born in Scotland, had had a high-school education, and had made a good living as a machinist. All that he knew about his mother was that she had married again. As far as he could find out, he had no brothers or sisters.

John lived in an orphanage until he was six years of age; whereupon an attempt was made at foster-home placement. The attempt failed miserably and was followed by trials in various other foster homes. In each of these homes, he was declared unmanageable and was returned to the orphanage. It was at this early age that John began his delinquent career with stealing money from the purses of his foster parents. He was involved in numerous similar delinquencies thereafter.

John was sent to school when he was seven. He was regarded by his teachers as unmanageable and a source of continuous trouble-making. However, he did complete the fifth grade at the age of fifteen before being finally expelled from school.

At the age of fifteen or sixteen, John was arrested and sentenced to eighteen months in an industrial school for forgery. Later he was also convicted of

the soldier (1) had one parent with high-school education, education of the other unknown; (2) he was of low average intelligence; (3) his first delinquency occurred when he was under eleven; (4) he was over fifteen when he began to work; and (5) he was an unskilled worker at the time of induction. By consulting the list of scores on pages 463-64, the reader will see that on Item 1, John Doe scored 66.7; on Item 2, 29.3; on Item 3, 66.7; on Item 4, 47.3; and on Item 5, 49.4. These scores total 259.4, which is John's prediction score.

The distribution of the scores on the 200 cases into their appropriate score classes is seen in Table II.

breaking and entering and served eighteen months for this. After being released from prison, he was sentenced again for statutory rape.

John's work history shows that he did very little work, with the exception of helping his foster parents on a farm while attending school and later working for about three weeks as a laborer in a steel factory. At no time did he learn a trade of any kind.

John married at the age of twenty-one and has one child. However, he states that he is not happily married and blames this on the fact that his wife runs around with other men. He claims that his wife's parents support her, but the social worker's investigation reveals that she received relief in order to exist after John enlisted in the army.

John enlisted in the army March 2, 1942, when he was twenty-two years old. He states that he liked his period of service in the army and that he got along well with his superior officers. He deserted, however, in September, 1942. In February, 1943, he was court-martialed and sentenced to two years at a rehabilitation center. He states the reason that he deserted was that his wife was running around with other men.

While at the rehabilitation center, John was tested and interviewed by the psychologist and was found to be of low-average intelligence. A diagnosis of psychopathic personality was made by the psychiatrist. The investigation of his social background revealed the fact that he was regarded by his foster parents, teachers, and neighbors as a friendly and attractive child, but one who always wanted his own way, a show-off, a ring-leader in mischief, a thief, and one who was never deterred by punishment. He was regarded by the psychiatrist as being emotionally unstable and lacking in a sense of responsibility and was, therefore, not recommended for restoration to duty.

During his early confinement in the rehabilitation center, John impressed every one as being a very likeable, jolly boy who was anxious to make good as a soldier. He frequently alluded to the fact that the army was his home and that he wanted to be a thirty-year man in the service. At first he impressed most of those associated with him as being a good risk for restoration back to duty. His instability finally showed up, however, in his escaping confinement and being involved in a kidnaping charge. It is now readily seen that he could never make a successful adjustment to army life.

CIVILIAN DELINQUENTS IN THE ARMED FORCES 467

TABLE II—DISTRIBUTION OF GLUECK PREDICTION SCORES ON 200 CIVILIAN OFFENDERS NOW AT REHABILITATION CENTER

<i>Prediction score</i>	<i>Cases</i>	
	Number	Per cent
Under 180.....	11	5.5
180-190	20	10.0
190-220	74	37.0
220 and over.....	95	47.5
	200	100.0

Reference to the prediction table (Table I) itself reveals the extent to which it would have been possible to foretell, at the point of induction of these men, that they would commit military offenses (as they did). The soldiers who scored *under 180* in respect to the five predictive factors (5.5 per cent of the total) had 8 in 10 chances of not committing military offenses in the armed forces; those who scored between *180-190* (10 per cent of the group) had a little over a 50-50 chance of not committing military offenses; those who scored *190-220* (37 per cent of the men) had only 3½ in 10 chances of being non-delinquents in the armed forces; while those who scored *220 and over* (47.5 per cent of the men) had only 3 in 10 chances of non-delinquency in the armed forces.

In other words, the soldiers whose failure score was *190 or over* fell into the group whose chances of non-delinquency in the armed services were slim. In fact, such cases constituted *84.5 per cent of the 200 soldiers*; while the chances of good behavior in the army of an additional 10 per cent were only a little more than 50-50; and in only 11 instances (5.5 per cent) would the Glueck prediction table have indicated a good likelihood of non-delinquency in the army.

Most conservatively, therefore, it can be stated that in at least 85 per cent of the 200 cases, recommendation for induction into the army might wisely have been denied on the basis of the Glueck prediction scores alone.¹

¹ The Gluecks would have liked to have the opportunity of checking another series of civilian offenders now in the armed forces who, unlike the group described in this article, are *not* committing military offenses. Such a checking is unfortunately not possible at the present time. It should be noted, however, that the original prediction table from which the results described in this

V

Although it is not strictly essential to this discussion, it may be of interest to the reader to know (1) what were the military offenses committed by these 200 men that brought them into a rehabilitation center; (2) what were the psychiatric diagnoses on these 200 soldiers; and (3) what were the prognoses made by the psychiatrist at the rehabilitation center regarding the probable future adjustment of these men to life in the armed forces after treatment at the center.

In regard to the military offenses committed by the 200 soldiers which resulted in bringing them to the rehabilitation center, they are as follows:

TABLE III—MILITARY OFFENSES OF 200 CIVILIAN OFFENDERS NOW AT REHABILITATION CENTER

<i>Offense</i>	<i>Number of men</i>
AWOL or desertion.....	54
AWOL, breaking arrest, disobedience.....	3
AWOL, drunk and disorderly.....	2
AWOL with escape with theft.....	12
AWOL with escape or leaving without proper relief or both....	3
AWOL with escape, other offense.....	16
AWOL and impersonation.....	3
AWOL with escape and disobedience.....	3
AWOL with escape and theft.....	4
AWOL, hot checks.....	3
Theft .. .	25
Theft and assault.....	3
Theft, personal use of government property.....	4

article have been derived (see Table I) was based on 48 per cent of civilian offenders who did not commit military offenses in the armed forces during the last World War and 52 per cent who did. It seems reasonable to conclude, therefore, that if one side of the table works, the other side of it would work equally well, based as it is on the same set of cases and the same raw materials.

The Gluecks are actually at present engaged in such a check-up in a series of 500 delinquents whom they are now studying and many of whom are serving in the armed forces. They are working out the prediction scores on these cases on the basis of the prediction table dealing with the behavior of former juvenile delinquents in the armed forces as published in *Juvenile Delinquents Grown Up* (Table 84, p. 214) and filing these away for future reference. When the present war is over and data can be obtained concerning the conduct of this group in the armed forces, they will have a check on both successes and failures, the expectation being that about half the group will have been non-delinquents in the armed forces and the other half delinquents.

CIVILIAN DELINQUENTS IN THE ARMED FORCES 469

TABLE III—Continued

<i>Offense</i>	<i>Number of men</i>
Desertion with escape.....	8
Desertion and theft.....	4
Desertion, bribery, disobedience.....	2
Disobedience	6
Disobedience, assault.....	1
Disobedience, assault, drunk and disorderly.....	2
Disobedience, assault, theft.....	3
Hot checks.....	7
Forgery	2
Fraudulent enlistment and bigamy.....	3
Fraudulent enlistment, theft, AWOL, disobedience, drunk and disorderly	7
Sleeping or drunk on post.....	7
Assault	6
Sex offenses other than sodomy.....	3
Bribery	2
Manslaughter	1
Burglary	1
<hr/>	
	200

Concerning the psychiatric diagnoses (which were made at the rehabilitation center), the reader should bear in mind the fact that the computation of the prediction scores was made without access to the diagnoses; these had been completed before the present investigation was begun. These diagnoses were based on psychiatric case histories which incorporated information gathered from many sources—reports from F.B.I. and local police; data obtainable from service records and other army records; questionnaires filled out by the soldiers' employers, teachers, parents, relatives, and former army associates; hospital reports; social histories from the Red Cross; and interviews by the psychiatrist and by the psychologist.

A distribution of the 200 cases by psychiatric diagnoses was then made. The results are shown in Table IV.

From this table it is readily seen that 130 of all the 200 men (65 per cent) were diagnosed as psychopathic personalities; 32 (16 per cent) as psychoneurotics; 4 (2 per cent) as psychotics; 2 (1 per cent) as having post-traumatic syndrome; 22 (11 per cent) as essentially normal; and 10 (5.0 per cent) as simple adult maladjustments.

Assuming that all those among the 200 civilian-offender

TABLE IV—PSYCHIATRIC DIAGNOSES ON 200 CIVILIAN OFFENDERS NOW
AT REHABILITATION CENTER *

Psychiatric diagnosis	Cases	
	Number	Per cent
Psychopathic personality.....	130	65.0
Psychoneurosis	32	16.0
Psychosis	4	2.0
Post-traumatic syndrome.....	2	1.0
Essentially normal †.....	22	11.0
Simple adult maladjustment ‡.....	10	5.0
	200	100.0

* The proportion of mentally deficient persons included in the following general categories is 4 per cent.

† An "essentially normal" person is one who is emotionally stable, is mature in his thinking, has a sense of responsibility, and is normally sensitive to social values.

‡ "Simple adult maladjustment" is used to designate an individual of normal stability whose excessively emotionalized reaction has been brought about by unusual stresses and strains in his environment, such as family troubles, financial troubles, or problems arising out of the sudden transition from civilian life. The individual is conscious of the fact that he is emotionally upset; and is conscious also of the various factors that contribute to the conflict. This is in contrast to the psychoneurotic, who also has an emotionalized reaction, but who is not entirely conscious of the reasons for his reaction.

soldiers who had been diagnosed as psychopathic personalities, as psychoneurotics, or as psychotics, and those diagnosed as having post-traumatic syndrome would have been rejected for army service at the point of induction had these diagnoses been then known, a total of 168 of the 200 cases would have been excluded. *This is 84 per cent.* The reader will recall that by utilizing only the prediction score, which is based on five factors and does not include psychiatric diagnoses, *85 per cent of the men* would have been definitely rejected.

It is, therefore, next of interest to determine the relationship between the psychiatric diagnoses and the Glueck prediction of chances of delinquent behavior in the armed forces. Table V shows this correlation.

Of 32 men who were diagnosed as *essentially normal* or having *simple adult maladjustment* and whom an induction board would, therefore, probably have passed as good risks for the army, 21 (65.6 per cent) would have been excluded on the basis of the prediction score alone as being *poor risks*, while there would have been hesitation in taking another 6 of these men (18.8 per cent) since their likelihood of delinquency in the army was only a little less than 50-50; and

CIVILIAN DELINQUENTS IN THE ARMED FORCES 471

TABLE V—CORRELATION OF PSYCHIATRIC DIAGNOSES AND GLUECK PREDICTION OF DELINQUENT BEHAVIOR IN ARMED FORCES

Psychiatric diagnoses	Chances of delinquency in armed forces						
	High (6½-7 in 10)		Fair (4½ in 10)		Low (2 in 10)		
	Num- ber	Per cent	Num- ber	Per cent	Num- ber	Per cent	
Psychopathic personality, psychoneurosis, psychosis, post-traumatic syndrome...	148	88.1	14	8.3	6	3.6	168
Essentially normal, or simple adult maladjustment.....	21	65.6	6	18.8	5	15.6	32

only five of these 32 men (15.6 per cent) would have been considered sufficiently good risks on the basis of the prediction table to warrant induction. Thus 84.4 per cent of the 32 men who might have been considered *good* risks on the basis of psychiatric study would have been *excluded* on the basis of the prediction table alone. Actually, of course, these men are giving difficulty in the army. Contrariwise, of the 168 soldiers who would have been rejected for army service by the psychiatrist as being either psychopathic, psychoneurotic, or psychotic, only 6 (3.6 per cent) of the total would have been judged *good* risks (*i.e.*, not likely to commit military offenses) on the basis of the Glueck prediction scores.¹

It was of interest to the collaborators of this article to determine how the prognoses made by the psychiatrist after thorough examination at the rehabilitation center (all of these were, of course, completed long before this study was

¹ Differences in the background of offenders seem not to affect the applicability of the tables as long as the predictive factors themselves are available and are accurately scored. For example, in the Glueck series of 131 cases on which the original prediction table was constructed, all were residents of the state of Massachusetts, 64.8 per cent were Catholics, 31.3 per cent Protestants, and 3.9 per cent Hebrews. In the rehabilitation-center series, on the other hand, the men were residents of 24 different states, 20 per cent were Catholics and 80 per cent Protestants. A further indication of the difference in the background of the two series is revealed in the fact that in the Glueck series 82.4 per cent of the men came from large cities, 6.2 per cent from small towns, and 11.4 per cent from rural areas, while in the rehabilitation-center series 24.5 per cent were from large cities, 37 per cent came from small towns, and 38.5 per cent from rural areas.

undertaken) correlated with the probable outcomes as indicated by the Glueck prediction table.

The psychiatric prognoses cannot of course be compared with the prognoses made on the basis of the prediction table because the former refer to the probable adaptation of the soldier to further life in the army after treatment in the rehabilitation center, while the prediction table, applied presumably at the point of induction, indicates the likelihood of delinquency in the army at any time in the army career. Nevertheless, the correlation between the two sets of prognoses is still of interest. This is shown in Table VI.

TABLE VI—CORRELATION OF PROGNOSSES OF PSYCHIATRIST AFTER EXAMINATION AT REHABILITATION CENTER WITH GLUECK PREDICTION OF BEHAVIOR IN ARMED FORCES
Chances of delinquency in armed forces

<i>Psychiatrist's</i> <i>prognoses of further</i> <i>behavior in army</i>	High (6½-7 in 10)		Fair (4½ in 10)		Low (2 in 10)	
	Number	Per cent	Number	Per cent	Number	Per cent
Good	7	4.1	2	10.0	5	45.5
Fair *	59	34.9	10	50.0	5	45.5
Poor	103	61.0	8	40.0	1	9.0
Total	169	100.0	20	100.0	11	100.0

* Fair conduct and behavior were good at the center and, therefore, warranted definite consideration, but there was some question in the mind of the psychiatrist and the psychologist as to whether the men would make satisfactory soldiers, in view of their having a tendency to react in an emotionally unstable fashion to situations other than the routine situations at the center.

It will be seen that in only 4 per cent of the cases who, on the basis of the prediction table, were poor risks for the army, did the psychiatrist and the psychologist consider that the soldier would make a good later adjustment; while in 10 per cent of the cases of those who were judged on the basis of the prediction table to have only a little more than a 50-50 chance of non-delinquency in the army, the psychiatrist and the psychologist considered that the men would make a good later adjustment. In the group of 11 cases that the prediction scoring showed to be probably good risks, only one was considered by the psychiatrist and the psychologist a really poor risk for further service in the army.

VI

CONCLUSIONS

The findings of the present investigation indicate clearly that among individuals who have been delinquent in civilian life, those who are likely to be delinquents in the army can be selected with a high degree of accuracy by use of the Glueck prediction tables alone.

It is not the purpose of this article to discuss at length where or how such a prognostic instrument could be utilized most profitably by the army. The magnitude of the problem of delinquency in the army is well known to many army officers. The time and expense involved in apprehending, investigating, trying, and confining army offenders is enormous. That attempts to rehabilitate many army offenders will prove futile is also readily appreciated by those familiar with this work.

There are, however, a number of persons in the army who have been assigned the task of determining whether or not the men whom they examine will make a successful adjustment to military life. To these persons the writers feel justified in suggesting, on the basis of the findings discussed in the present study, that the use of the Glueck prediction tables would be valuable to their work. The reader will recall that predictions made on the basis of the Glueck prediction tables compare in accuracy most favorably with predictions made on the basis of comprehensive psychiatric case histories incorporating information gathered from many sources.

There are many difficulties involved in attempting to define objectively those traits of character or personality which should constitute the basis for rejecting men at induction stations, discharging them from the service, or not restoring them to duty from rehabilitation centers. It is not here suggested, therefore, that in the case of individuals who have been delinquent prior to entering the army, standardization can be achieved. It does appear to the writers, however, that the findings in the present investigation have a definite value in calling to the attention of psychiatric examiners, and the officers with whom they work, the par-

ticular factors in the background of a delinquent that are of extreme importance in any determination of his future adjustment to life in the army.

APPENDIX

The first step in the construction of a Glueck prediction table was to correlate each factor in the research with the behavior of the group of offenders during the particular form of treatment for which a table was to be made. After these correlations had been made, those factors were selected for *possible* use in a prediction table which were found to bear a sufficiently high relationship to behavior during the particular form of treatment to be of prognostic value.¹

It has been found adequate to choose five out of such a total group of factors on which to construct a prediction table, and experience in numerous researches has shown that it is not necessary to utilize those five factors which bear the very highest relationship to behavior during a particular form of treatment. (Selection of factors is determined either by inspection or, in doubtful cases, through computation of a coefficient of mean square contingency.) It is necessary only that the group of factors selected bear a sufficiently high association to behavior to assure a workable prognostic instrument.

For practical purposes, several other considerations entered into the actual selection of the predictive factors. First, of any series of possible factors that might have been included among the five on which a prediction table was to be constructed, those were chosen about which accurate information was available in the greatest number of cases in the series from which the table was derived; too many "unknowns" would have seriously reduced the statistical validity of the resulting table. Secondly, in constructing a table it was necessary to look ahead to its applications; another practical consideration, therefore, had to do with the ease with which courts and other institutions or agencies would, in practice, be able to obtain the needed data about any particular offender in respect to the five factors. If there was a sufficiently wide choice of factors of essentially equal prognostic power on which to base a table, the Gluecks found it advisable to eliminate those factors on which it would be difficult for courts and other agencies to secure information. For example, if *Mental condition* happened to be a factor that was highly related to *Behavior during a particular form of treatment*, this factor was, as a rule, not utilized in the construction of a prediction table if there was another factor that had almost equal prognostic power and that a court or parole board or other authority could more readily secure about a given offender, such as, for example, *Birthplace of father*.

¹ George B. Vold, in "Prediction Methods Applied to Problems of Classification within Institutions" (*Journal of Criminal Law and Criminology*, Vol. 26, pp. 202-209, 1936) found the substantial coefficient of correlation (*r*) of .92 between the Burgess method, which utilizes all available factors, *unweighted*, and the Glueck method in which five weighted factors are used. In 1932, Elio Monachesi, in his book, *Prediction Factors in Probation* (Hanover, N. H.: The Sociological Press, 1932) applied the Glueck prediction method (as originally developed in *500 Criminal Careers*) and the Burgess method, which utilizes *all* factors in research, *unweighted*, to 403 juvenile probation cases of Ramsey County, Minnesota. He reported (p. 108) a coefficient of correlation (*r*) of .862.

CIVILIAN DELINQUENTS IN THE ARMED FORCES 475

The Gluecks are fully cognizant of the technique of selecting prediction factors from among those that are not intercorrelated. But in view of the limitations of their data, and the greater practical importance of other considerations in the selection of the factors, this technique has not been applied except in so far as their understanding of the meanings of the factors has determined a choice of those that are less, rather than more, interrelated, all other considerations being equal. They think, too, that there might be some wisdom in deliberately using five partially interrelated factors rather than, say, three purely independent ones; because in considering the practical application of the tables, an error in classification on the part of those who would be charged with the gathering of information for determining an individual offender's prediction score would not have the serious consequence that would ensue if the prediction tables were based on only three wholly independent factors.¹

Once the factors to be utilized in a prediction table had been selected, the next step was to set down the percentage incidence of recidivism during the type of treatment for which the table was being constructed. For example, suppose it has been determined by correlating the factor *Age at first delinquency* with *Behavior during probation* that of those offenders who were *under fourteen* when they first became delinquent, 36.3 per cent continued to be delinquent on probation; while of those in the sub-category of *fourteen or older* when they first became delinquent, only 24.7 per cent continued to be delinquent during probation. Such a finding would show at once that the age at which an offender first became delinquent somehow bears a relationship to his behavior during probation; and since this is so, *Age at first delinquency* has prognostic value and can be included in a prediction table. These percentages represent the "prediction score"—*i.e.*, the likelihood of recidivism or adjustment of offenders falling within certain sub-categories of each of the five factors on the basis of which the particular prediction table was constructed.

By adding the percentage incidence of the lowest possible failure score in each of the five selected factors, on the one hand, and of the highest possible failure score, on the other, the two extremes of a "prediction score" were arrived at. Within this zone all the offenders were distributed. This zone was next divided into sub-zones or "score classes." The particular score classes that resulted in the sharpest predictive instrument varied from table to table. The first tabulation of cases was made into detailed score classes (10-point intervals). The resulting table was then studied in order to see what combination of score classes provided the sharpest differentiation between the successes and failures.

A distribution was then made of the offenders in accordance with the score class in which each offender belonged and this was in turn related to their actual behavior during the particular form of treatment for which the table was constructed. From the resulting correlation table it became possible to forecast the probable behavior of other offenders with similar characteristics.

The interested reader is referred to the chapters on prediction in the various books of the Gluecks above mentioned.

¹ For further details, see *Criminal Careers in Retrospect*, p. 221, note 15.

PENNSYLVANIA'S MENTAL-HEALTH PROGRAM*

WILLIAM C. SANDY, M.D.

*Director, Bureau of Mental Health, Pennsylvania Department of
Welfare, Harrisburg*

IN this discussion of the Pennsylvania mental-health program, the principal emphasis will be on the activities of the bureau of mental health and the facilities under its supervision.

The bureau of mental health has had a program ever since it was established with the department of welfare in 1921, and this has been gradually developed on a definite legal basis. The administrative code defines the duties, powers, and responsibilities of the bureau in respect to mental patients. These are, briefly, "to administer and enforce the laws of this Commonwealth relative to the prevention of mental diseases, mental defects, epilepsy and inebriety, the admission and commitment of mental patients to hospitals for mental diseases and institutions for mental defectives and epilepsy, and the transfer, discharge, escape, interstate rendition, and deportation of mental patients."

Over the years, policies and procedures have been formulated, standards established, building programs evolved, new institutions developed, old institutions modernized and expanded, and activities for prevention promoted and participated in. Under present circumstances and for the duration of the war, progress has necessarily slowed down. Some activities regarded as essential may have to be limited or even discontinued for the time being because of shortage of personnel, priorities, and other war-time conditions such as we are all experiencing.

Let us consider the program of the bureau of mental health, the institutions under supervision, and the coöperating agencies rather sketchily under five general heads: hospi-

* Presented at a meeting of the Luzerne County Medical Society, Wilkes-Barre, Pennsylvania, October 20, 1943.

talization, rehabilitation, prevention, research and education, and inspection.

As to hospitalization or institutionalization, this is effected under the provisions of the Mental Health Act of 1923, through voluntary admission, commitment on the certificate of two physicians, or a commission, or two physicians with court action, on forms prescribed by the department of welfare. These forms vary according to types of patient—*i. e.*, the mentally ill or so-called insane, the epileptic, and the mentally defective or so-called feebleminded—and the institution to which commitment is made. Care must be exercised that the person for whom admission is desired is eligible for the institution to which application is being made. For instance, only the mentally ill or the so-called insane may legally be admitted to mental hospitals. This obviously does not mean so-called "dotards," old people who are simply forgetful and in need of kindly custodial care, but who are not insane. Likewise mental hospitals are not proper places for feebleminded persons who are not psychotic. There has been a disquieting trend toward applications for admission to mental hospitals of an increasing number of harmless non-psychotic old people. This is unfair to the individuals concerned and places unnecessary additional burdens upon the mental hospitals, already fully occupied with the active treatment of psychotic patients.

After provisions have been made for securing adequate personnel and developing training plans for efficient service, there should obviously be facilities and personnel for such minimum objectives of public mental hospitals as the following:

1. Effective treatment and restoration of as many patients as possible, with assistance in community rehabilitation.
2. Appropriate treatment for special cases, with such classification and segregation as may be required.
3. Training to some degree of usefulness of as many patients as possible, utilizing occupational therapy and other forms of work activity.
4. Comfortable and safe custodial care of the psychotic

aged and other more or less helpless types of patient who remain in the hospital.

5. Consideration of such other methods as boarding out or family care, the establishment of community occupational centers for suitable paroled patients, and other innovations as they may be suggested.

As to rehabilitation, mental hospitals should make strenuous efforts to return to the community patients who have recovered or who are sufficiently improved no longer to require hospitalization. This means a constant review of the condition of patients by the medical staff and the assistance of a competent social-service department in investigating and preparing the home for the paroled patient and in helping suitable patients to secure jobs, thus expediting the return to the community of proper cases.

As to the standards of mental hospitals in general, definite progress has been made. In the interests of the citizens of Pennsylvania, complete state care of mental patients has long been advocated, as it is believed that equally high standards of study, treatment, and care of mental patients should be made available throughout the commonwealth. This was not possible under the dual system of state and county care. State care has recently been established and the arrangements for it are now nearing completion.

Mental hospitalization is a medical problem; the objective, therefore, is to have trained superintendents, physicians, who are psychiatrists and mental-hospital administrators, who are diplomates of the American Board of Psychiatry and Neurology.

It is our purpose, also, to increase the number of graduate nurses, replacing untrained attendants; also to have a well-organized social-service department.

Prevention is a most important part of the program, but the results are often difficult to evaluate. All public mental hospitals should recognize their community opportunities and responsibilities. Mental clinics for persons who need advice and for parole cases, also guidance clinics for problem children, are activities that undoubtedly often obviate the necessity for commitment or return to a hospital. Such clinics, if adequate, should be provided with a psychiatrist,

a psychologist, and a social-worker personnel, usually from the staff of the mental hospital receiving patients from that community.

Other forms of prevention are efforts to inform the public as to mental hygiene through talks and press releases, and participation in such activities as induction-center screening of potential mental cases from selectees. Groups of students and other public-spirited citizens frequently meet by invitation at the various institutions and thus learn of the facilities, the activities, and the needs of these institutions.

Research and educational training are closely related parts of the program. All mental hospitals have unsurpassed opportunities for organized study of patients through the consideration at staff conferences of diagnoses, treatment, and such questions as parole, post-mortem examinations, and so on. Courses for assistant physicians have been made available. Especially to be mentioned are the courses provided for seventeen years by the Postgraduate Department of the University of Pennsylvania Medical School, reluctantly, but unavoidably discontinued for the duration because of shortage of hospital personnel.

Pennsylvania has maintained an undergraduate school for nurses of both sexes at Danville, and affiliate nurses' schools at Allentown and Warren. It is probable that Danville will become an affiliate school. Other affiliate schools are contemplated at Norristown and Philadelphia, thus preparing for the provisions of the Bolton Act, which establishes cadet-nurse training activities.

At the hospitals, training opportunities have been established for attendants. For psychologists, dental hygienists, and social workers, opportunities for experience, a type of internship, have been made available. During the summer, medical students have been accepted for experience as clinical assistants.

Recognizing that governmental agencies should assume greater responsibility for formal research in the etiology, treatment, and prevention of mental disorders and their complications, the commonwealth, after years of effort, succeeded in establishing the Western State Psychiatric Hospital on the campus of the University of Pittsburgh,

for research and for the educational training of medical students, graduates, and other personnel in psychiatry and related subjects.

The accumulation of patient records—including data on admissions, diagnoses, deaths or discharges, and accidents and injuries—and the compilation and publication of statistical information are important activities within the bureau of mental health and the section on statistics of the department of welfare.

Inspection at least once a year of all institutions for mental patients is mandatory by law. In normal times, a senior staff member of a state-owned institution is selected annually to make a complete survey of all mental hospitals and institutions for mental defectives, including the state-owned and the licensed private institutions—some sixty-five in all. More frequent inspections are made by the personnel of the bureau of mental health. Copies of the reports are sent to the superintendents, for their information, comment, and stimulation.

The foregoing discussion has been concerned primarily with the mentally ill, prevention, treatment, and rehabilitation. Time limits will not permit an adequate discussion of the problem of mental deficiency—a topic that merits a separate consideration. Involved are such questions as incidence; the present-day belief that institutionalization is possible and necessary for not more than 10 per cent of the cases; the overcrowded institutions with long waiting lists; community provisions, such as special classes, occupational training, and supervision; the possibility of prevention of a larger number of cases by improved obstetrical technique; the controversial question of sterilization; and so on.

Furthermore, a complete mental-health program involves agencies, facilities, and activities beyond the scope of the bureau of mental health. For instance, childhood is often designated as the "golden period for prophylaxis in mental disorder and defect." Consider the implications of this idea as a slogan. The health and educational authorities are immediately brought into the picture. Early and more thorough physical examination of children is indicated, with the correction of remediable defects, neglect of which may be a factor in the development of misunderstanding, difficult

behavior, or even mental disorder. Early psychological examination of children will bring about a better understanding of the intellectual level and form a basis for modification of education according to ability and requirements. More extensive provisions for special classes will assist the handicapped. Visiting teachers and student counselors, through contact with homes and parents, will bring about a better understanding of the pupils and their needs. Teachers with some appreciation of psychiatric and psychologic problems (including their own) will more successfully guide their pupils.

Such a program may not be fully possible, especially in these critical times, but the objectives should be among those toward which we strive. A beginning has been made and some of the elements of the program have been at least partially adopted. A more complete utilization of such a plan would, it is believed, result in better integrated personalities, less maladjustment, greater success and happiness.

BOOK REVIEWS

PSYCHIATRY IN WAR. By Emilio Mira, M.D. New York: W. W. Norton and Company, 1943. 206 p.

Writing from the point of view of psychiatrist-in-chief to the Spanish Republican Army, Dr. Mira presents two main topics for consideration to his American audience. The first of these centers around the rôle psychiatrists should play in directing and supporting morale in war time. The other is a review of his experiences with neuropsychiatric casualties during the war, together with his point of view toward treatment.

Like many American psychiatrists, Dr. Mira deplores the ineffectiveness of modern psychiatry as a tool in morale-building programs and in sociological mobilization for total war. He analyzes with detailed care the emotional factors in the population that reverse themselves during war time from their peace-time states. "Broadly speaking, in peace time," he says, "interpersonal relations take place in a frame of confidence, gentleness, and friendship, whereas in war time they are tinged with reluctance and harshness. In time of peace, a normal man is rarely angry and still less often afraid. In time of war, on the other hand, it is a luxury to be calm and good-humored." He particularly stresses the flexibility of emotions demanded of the ordinary soldier or civilian in time of war, as hatred against the enemy and love of his superior, warmth and friendship toward companions, and still an attitude that allows one to suspect one's companions of treason or failure in line of duty.

A chapter is devoted to an analysis of fear and another to anger. Dr. Mira observes that in war a blending of fear and rage are usually seen instead of either in pure form. Most psychiatrists would feel that in human beings neither fear nor rage exists independently, but that they always accompany each other to a greater or lesser degree. Fear and rage combine to produce the motivating power behind the military machine. In states of good morale, this force is directed outward against the enemy, but the usual dislocations of drive direction may occur, and in them violence may be transposed into rage against the civilian population or jealousy and malice in the ranks.

The importance of psychiatric screening of candidates both for officers and for men is discussed in some detail and the method of selection used by the Nazi army is described. This included psychological testing, careful and prolonged observation of the candidate, and study of his personal history. A good deal of attention was given to personal observation by experts of the behavior and responses of

the candidate during ordinary social exchanges, over quite a period of time (several days). These data were apparently given equal value with that of the psychological tests. The brief screening test devised by Dr. Mira and used by the Spanish Republican Army is included. This consists of eighteen questions. The first five were about orientation in the current ideology and were used largely as a measure of intelligence and schooling. The rest deal with psychoneurotic symptomatology.

Most American psychiatrists will feel dissatisfied with Dr. Mira's psychiatric classifications and statistics, and with many aspects of the treatment he recommends. About the psychoneuroses, he makes the observation that "the overwhelming majority of the war neuroses is constituted by conversion hysteria," and with this premise he recommends treatment with the faradic current and other painful, barbaric, and degrading methods. Toxic psychoses are to be treated by turpentine abscesses in the lumbar regions. However, he also includes methods that are used in English and American treatment centers, and psychotherapy, as we would understand it. But he lays great emphasis on shorter, dramatic techniques, such as hypnosis, insulin, and shock.

The figures he gives on mental casualties in the Spanish Republican Army are astonishingly low, constituting less than one-half of 1 per cent of the total casualties. The patients recorded by these statistics had already passed through treatment centers before reaching his hospital, but the percentage is still not comparable with figures obtained in other military scenes.

There are many stimulating points developed in this book. The idea that psychiatry should play an important part in maintaining and establishing war morale is no new idea to American psychiatrists, but the technique by which Mira would like to put such a program in motion is not too clear. Many of us have become dissatisfied with the limitations imposed on us by the usual medical approach—that is, to the individual patient—and have felt, like Mira, unable to help the individual without modifying the population of which he is a part. Some of us have turned to sociology, social psychiatry, and social work for the tools with which to bring about this change in environment and climate. American psychiatry is perhaps to be criticized rather for its failure to move with consistency and flexibility in coöperation with other social disciplines than for its failure in rigid verbal planning. Also, most psychiatrists are well aware of the importance of early treatment of war neuroses and of the fact that some dramatic methods may justifiably be used to bring about speedy remissions. Many of us, however, will recall Dr. John Whitehorn's epigram that the greatest damage done by shock therapy is the damage

done to the doctor who administers the shock, and will be cautious in advocating some of these methods.

Dr. Mira has some difficulty with the English language, and some of the obscure thinking encountered in parts of the book is due, I am sure, to poor translation. The book itself, however, presents a point of view, a body of interesting material, and is an important contribution to modern military psychiatric thought.

MARGARET C.-L. GILDEA.

St. Louis, Missouri.

HUMAN CONSERVATION; THE STORY OF OUR WASTED RESOURCES. By Lawrence K. Frank, with the assistance of Louise K. Kiser. (National Resources Planning Board Pamphlet, March, 1943.) Washington, D. C.: Superintendent of Documents, U. S. Government Printing Office, 1943. 126 p.

The sovereignty of the person is his right to be valued and to have his choice of his own way of living respected as long as this does not obstruct a similar right of others. This sovereignty is still not strongly enough entrenched, even in modern democracy, to cause public anxiety when its curtailment is threatened. All sorts of preventable calamities happen to people and arouse little protest until their victims become a public loss. Human resources, it seems, may be squandered up to the point where man power becomes a matter of concern in the safety of all.

How extensive this squandering is appears in this pamphlet by Frank. It shows in brief form, with a free use of graphic presentation, the changes that are occurring in our population. It presents pictorially and descriptively the statistical facts about the wastage in the prenatal, neonatal, pre-school, elementary-school, adolescent, adult, late-maturity, and old-age periods. It quantifies the loss by death, accidents, illness, impairment and malfunctioning of behavior (mental deviation, work or school failure, and anti-social disorder). It is an excellent composite of facts on human life given in good balance and made accessible to those who need them.

The disturbances of mental health constitute a very large part of this wastage, and appropriate place is given to a presentation of these disorders, including not only those that are obvious, but the more subtle psychological elements in accident and illness. Even beyond these, the fact that the public tolerates wastage is explained as a result of mass mental and emotional resistance without a knowledge of which the physical disorders, accidents, impairments, and loss cannot be forestalled.

The last chapter offers suggestions for the study of one's community in order that the human resources may be understood and dealt with.

GEORGE S. STEVENSON.

The National Committee for Mental Hygiene.

PAPERS IN HONOR OF EVERETT KIMBALL. *Smith College Studies in Social Work*, Vol. 14, No. 1, September, 1943. 230 p.

This volume of papers, by representative alumnae and faculty of the Smith School for Social Work, is a testimonial not only to Professor Kimball, but to the school of which he was director for twenty-two of its twenty-five years of existence. The twenty-four authors have contributed twenty-three articles—one article is the joint product of two alumnae—and Dr. William A. Neilson, President Emeritus of Smith College, the appreciative foreword. Since each author was free to select his own topic, there is of course a diversity of subject matter, and the book cannot be reviewed as a unit except in the most general terms. To comment on particular articles might be a disservice to the prospective reader, whose interests might be quite different from the reviewer's, and an injustice to all those authors whose articles would not be mentioned solely for lack of space.

Despite the diversity referred to, it was possible for the editors to group the papers, with one exception, under the headings: *The War* (six papers); *Case-Work Theory* (three papers); *Mental Hygiene* (three papers); *Case-Work Practice* (seven papers); and *Research and Training* (three papers). It is of course not surprising that, given free choice, there result two peaks of interest—the war, which is the current crisis on which all eyes are fixed, and case-work practice, which will, hopefully, remain a permanent area of major concern for those who engage in active work in case-work agencies.

A point of significance is that the Smith College School for Social Work was the direct outcome of the need that arose in World War I for social case-workers equipped, as Dr. Neilson puts it in his foreword, to give service to "larger numbers of nervous and mental cases than our reserves of psychiatrists were prepared to handle." On the eve of the twenty-fifth anniversary of the school, the nation found itself confronted with a still larger problem, both qualitatively and quantitatively, arising from this second, and total, World War. The authors of this book have, however, all practiced or taught in the years between these two crises, and it is impossible not to be impressed by the enormous range of their activity, the various settings in which they have worked and put to use the skills and knowledge acquired at the Smith College School. (The three psychiatrists, members of the

faculty, will forgive their exclusion from this observation.) Other studies have of course illustrated this point, but it is a characteristic of this book that gives it a particular and valuable flavor.

Just one more general comment—for the most part the contributors to the volume are actively engaged in practicing social case-work at some level of operation or in teaching it. While it is natural and always helpful to draw on individual professional experience, there are a rather high number of papers that refer seldom, or not at all, to other sources than the author's personal experience. This inevitably raises the question whether we are sufficiently alert to the experience and ideas of others, whether we make maximum use of them, whether we do not too frequently operate in a professional isolationism that thins the value of our own contributions to practice, theory, and professional literature.

This is a group of articles that should be read widely, that can be most usefully referred to by students and practitioners for light on specific problems, and that bear significantly on questions related to theory as well.

JEANETTE REGENSBURG.

*Tulane School of Social Work,
New Orleans, Louisiana.*

MAN THE MECHANICAL MISFIT. By G. H. Estabrooks. New York:
The Macmillan Company, 1941. 251 p.

Man has created a highly complex civilization which requires unusual ability to run. But this achievement may be destroyed because the source from which such ability must be recruited is diminishing. Race suicide is more extensively practiced in the higher groups than in the lower. So, too, is the back-breeding of inherited defects. "We are demanding more and more ability from a constantly decreasing supply." The supply might be increased by a careful process of selective breeding; but the outlook for such a program is not encouraging. When the output of ability fails to equal the demand, our civilization will probably collapse, although for a few thousand years it may continue apparently intact.

These are the opinions that a professor of psychology in Colgate University voices in a book designed "to popularize a very unpopular thesis." The title is given by the fact that where the two-legged oddity bred by nature was the result of a ruthless weeding-out process, which enabled him to survive whatever faced him, now the doctors and the kindly social agencies of one sort or another are keeping the physical misfits alive and permitting a weakened stock to pass on to its descendants a more or less decrepit physical mechanism. Degen-

eration (every student of medicine or anthropology can give instances) is going on at a serious pace. Civilization protects and breeds bodies which nature, if left to herself, would wipe out. From this point of view, doctors, social reformers, and humanitarians are, for all their kindness, in the long run mankind's enemies.

Nor is there any evidence that to-day's brains are better than those of primitive days. "Better automobiles, bridges, radios, do not of necessity mean better brains," only brains better equipped. Though civilization now makes unprecedented demands on mental ability, race suicide among the abler groups may be compared to skimming off the cream of ability and throwing it away. Modern war sends our physically fittest to face the wholesale slaughter of machine guns and tanks.

Sterilizing the feeble-minded would be at least one step toward halting the procession toward degeneration. But majorities in a democracy will not listen to science, as the record of dead-letter sterilization laws (where such laws have indeed been passed) plainly indicates. And can morons be sterilized, or segregated, or taught restraint in sex? Any hope must lie in solving this problem of the feeble-minded and the moronic, stopping war, encouraging further research to "clear up our profound ignorance of human heredity." The Nazis have attempted a solution by ruthlessly killing off their "undesirables." Whether more humane methods can meet the need, remains to be seen. Very few doctors or philanthropists will cease their benevolent activities in behalf of suffering individuals or groups. Meanwhile, however, it is good for all of us to get such forthright warnings as these from Dr. Estabrooks. The first step toward meeting a need, if we can, is to be aware of it.

HENRY NEUMANN.

*Brooklyn Society for Ethical Culture,
Brooklyn, New York.*

PSYCHOLOGY IN NURSING PRACTICE. By Philip L. Harriman, Lela L. Greenwood, and Edward Skinner. New York: The Macmillan Company, 1942. 483 p.

The authors of this book are a professor of psychology, an instructor in nursing, and a professor of education. Obviously they know collectively a vast deal about the subject, and they have produced an important volume. Professedly, it is written both for nurses in training and for nurses in service. It will be somewhat heavy for the student, but may serve as supplemental reading. It is likely to be very helpful to instructors. Particularly in the earlier sections, it seems better adapted to schools that train nurses to teach than to

those who train nurses to nurse. It improves as it goes on and the later chapters are capital.

The book is set up to facilitate teaching the units recommended in the Curriculum Guide, and instructors will find the arrangement convenient. There are questions to promote discussions and generous reading lists after each chapter. Many of the references are recent, and there are admirable illustrations in the earlier chapters, particularly those taken from Williams.

The material on abnormal psychology and mental hygiene is somewhat compressed, and one hopes that a student who is following it will have well-timed and well-presented lectures and germane ward assignments at exactly the same time. The section on learning processes and mental and educational abilities should be helpful in the establishment of good study habits, and the chapters on biological development should integrate with the studies of anatomy and physiology.

One pays some penalties for multiple authorship. The earlier chapters of the book contain several slighting references to psychoanalysis, yet the same book lists psychoanalysis first among methods of treatment. The Rorschach test is rather lightly dismissed in an early chapter, but is well appreciated in a later one. One author evidently very much dislikes the concept of unconscious mentation. We doubt whether it is helpful to the pupil nurse to place her in a state of mind to resist what the staff psychiatrist may happen to say about his patient whom she is studying.

In other passages conflicts between psychological theories are presented. Many girls who make excellent nurses are in no position to weigh these differences, and are likely to use them to waste the instructor's time.

The first chapter on the mental processes starts off with an attack on mechanistic psychology. We wonder how many pupils have any idea as to what is meant. It seems misleading to say that the psychotic individual is completely out of touch with reality, and students may be puzzled by mention of a fixation of sexuality on the homosexual level. Do we know enough about the breakdown of synaptic resistance in the learning processes to justify even a mention of it? There should be a more helpful definition of introversion. Most paretics do not have typical delusions of grandeur. The characteristic of mixed manic-depressive states is not alternation.

There is a traditional discussion of the difference between the art and the science of nursing. In our opinion a great deal of the art of nursing consists of application of the principles of mental hygiene and can, therefore, be taught to most students. Still more applied psychology would be useful.

An appendix lists reference books. An efficiency record and a vitamin chart also are appended.

MARY E. CORCORAN.
SAMUEL W. HAMILTON.

*United States Public Health Service, Division of
Mental Hygiene, Washington.*

EMOTIONS AND MEMORY. By David Rapaport. Baltimore: Williams and Wilkins, 1942. 282 p.

It is the feeling of the reviewer that this monograph, the second in the Menninger Clinic Series, will make a definite contribution to the better understanding of psychosomatic relationships. The study had its origin in practical consideration of the problems relating to history taking and the desire to obtain the most accurate possible picture of the patient's past; and the author has successfully undertaken the Herculean task of amassing data from psychological, psychoanalytical, and psychiatric research literature.

The first chapter presents an outline of the general psychological background of the problem of emotions and memory. This is followed, in the second chapter, by a survey of the literature of emotions and by an attempt to clarify the meaning of "emotions and memory." In the third chapter, pertinent experiments reported in the literature of general psychology are surveyed; while the theoretical contributions of general psychology to the relationship between the emotions and memory are dealt with in the fourth. Psychoanalytic theory and observation are reviewed in the light of the present problem in the fifth chapter; the sixth surveys the relevant literature of hypnotic memory phenomena; the seventh discusses amnesias; and the eighth describes a number of experiments, tests, and techniques that appear to be demonstrations of the effect of emotions on memory. In the ninth and last chapter, the author summarizes his findings and presents a tentative interpretation.

In his conclusions, Dr. Rapaport states that it might be possible and perhaps useful to build a psychological theory of the emotions, which could later be amalgamated with corresponding physiological theory and knowledge. Further in the discussion he postulates the following:

"Such a theory [a psychological theory of the emotions] would be based on these recognitions: (a) that the emotions are expressions or discharge processes of energies, but not energies in themselves; (b) that the underlying field dynamics, of which emotions are discharge processes, are unconscious; (c) that inherent to the conditions characteristic of the genesis of emotions are conflicting instinctual strivings; (d) that the discharge process may be one of many processes. These dis-

change processes may be of the following kinds: (1) peripheral physiological changes, either transient, as in the case of emotional expression and related physiological changes, or chronic, as in the case of psychosomatic disturbances; (2) changes in the usual routine habitual behavior, either transient, as in the case of rage, or chronic, as in the case of behavior disorders of children; (3) organization of thought and memory processes of the person, either in a transient fashion, as in the case of slips of the tongue, or in a chronic fashion, as in the case of normal and pathological thinking."

This formulation represents careful consideration of all the critical thinking that has been gathered on the topic of emotions. The theory should go far in developing our understanding of the emotions and the mechanism of memory, for it expresses the ideology of many fields of human behavior and crystallizes the dynamic relationships into an everyday working hypothesis.

Elsewhere in his conclusions, Dr. Rapaport states that "the viewing of emotions in physiological terms prevented many investigators from seeing the possible interrelationship of emotions and memory, it prevented psychological analysis of this relationship." Unfortunately, this statement is true for many other problems that confront psychologists in the investigation of behavior. This idea leads to the final point discussed by the author; this, too, is important not only for the emotions and memory specifically, but for psychology in general. Since the investigation of emotional influence has led to the belief that unconscious determining factors exist, it is felt that psychoanalytic formulations should be intensively studied in psychological research, in order that there may be further development of what material can be realized from "psychoanalytic tenets" to increase our understanding of the emotions and memory function.

The text is both interesting and informative and, in spite of the complexity of the subject matter, makes smooth reading. The author's style is at once provocative and stimulating. He considers his material in reference to the topic proposed in the chapter and interjects findings directly from the literature to clarify and substantiate his points. Along with his theme he presents quotations and direct views in a manner that allows his reader to weigh and assay the material, so that he can form his own interpretation in the light of the material offered.

The usefulness of the volume is greatly enhanced by the subdivisions of each chapter. Also, each of the nine chapters is followed by a list of references for that particular section. Furthermore, there are two indexes—one an alphabetical list of authors, the other an alphabetical list of subjects. One realizes the breadth of this survey when one considers that approximately 630 references were studied for the source material in the effort to make the book one of

the most valuable that has yet been published on this particular subject.

Both the Josiah Macy Jr. Foundation and the Menninger Clinic are to be congratulated for their vision in giving Dr. Rapaport the opportunity and the encouragement to undertake such a project.

ARTHUR WEIDER.

*Psychiatric Clinic, New York University Medical College,
New York City.*

HYPNOTISM. By George H. Estabrooks. New York: E. P. Dutton and Company, 1943. 249.

Since the time of Mesmer, hypnosis has unfortunately been in general disrepute because of the widespread misunderstandings, superstitious beliefs, wishful thinking, strong prejudices, and melodramatic ideas that surround it and that are much more readily accepted than is factual information. Hence, any author who wishes to write a book on hypnosis necessarily undertakes a most difficult task. He must present factual information adequately for the reader's understanding. He must make that presentation sufficiently clear to controvert the serious misconceptions of hypnosis generally entertained, especially by those who have seen little or no hypnosis and who base their views of it upon vaudeville and comic-strip presentations, to the detriment of any scientific understanding. Then, too, the author must avoid with extreme care the lending of support, directly or indirectly, to unscientific, misleading, and distorted ideas of hypnosis, since it is inherently a subject of profound emotional interest. Indeed, the author must write with an exceedingly wary pen that distinguishes clearly and accurately facts and scientific concepts from fiction, melodrama, and uncontrolled speculation.

In writing this book with the aim of giving the layman an authoritative, comprehensive account of hypnosis, the author (for whom the reviewer has warm personal regard) unfortunately lacked a wary pen. On nearly every page, with equal weight and credibility, he presents accuracies and inaccuracies, fact and fiction, scientific thought and melodrama, cogent reasoning and uncontrolled speculation, consistencies and inconsistencies, relevances and irrelevances, all of which cause the thoughtful reader, even one with limited experience in hypnosis, to take serious exception to most of his presentation. As a consequence, any reader who wishes to profit from the actual good in this book would need a background of experience in hypnosis sufficiently great to make reading the book unnecessary.

Nor does the author limit himself to the subject of hypnosis. He unnecessarily throws in uncritical and often patently false assertions bearing upon various fields of psychological, medical, and psychiatric interest. The following citations will serve to illustrate some of his superficial, uncritical, and often naïve treatment of his subject matter.

On the opening page he makes the statement that "the individual who talks in his sleep and answers questions is really hypnotized." This said, he states in the next sentence, "In fact, this is one recognized method of producing the trance, namely by changing normal sleep into hypnotic sleep." Thus, in consecutive statements, the author declares that physiological sleep and hypnosis are identical and also that the one may be changed into the other, as he explains, by a "skilled hypnotist" or, as can be inferred, by an ill-chosen meal leading to gastric distress and vivid dreams. On page 129, however, the author declares that "sleep and hypnosis have very little in common," and on page 233, just ten pages from the end of the text, he finally recognizes that "hypnotism has nothing to do with sleep."

On page 16 he declares that 90 per cent of people can develop at least light hypnosis, but on page 35 he declares that only one out of five subjects will develop deep hypnosis, and that no hypnotist, "whatever his skill, can better this average." Yet, discussing medical uses (page 240), he states that hypnosis can be used as a sedative with effects superior to those of any drug on one-third of all adults and practically all children. Such sedation, if possible, would require deep hypnosis and not "moderate hypnosis" as suggested by the author.

Concerning the author's dogmatic statement that the average person is susceptible to light hypnosis only, it is this reviewer's experience that the subject who develops the phenomena of the light trance is a promising candidate for deep hypnosis. Personal work and the work of experienced colleagues indicate that at least seven out of ten subjects who develop light hypnosis can be trained to go into a deep trance. Perhaps this contradiction between the author and the reviewer can be understood in the light of the author's statement (page 24) that he "would never spend more than five minutes at any one séance" in the early training of subjects, although "he knows of excellent operators who will hammer right along for one hour if necessary."

Also, the author fails to realize that subjects potentially capable of deep trances can be trained unintentionally to limit their hypnotic behavior to light-trance phenomena by insufficient time-limited techniques in their early training. Indeed, this begrudging of time

in inducing a træe, despite an appreciation of hypnosis as a scientific phenomenon and not merely a parlor trick, is difficult to understand. In no other field of psychological research is the importance of time so arbitrarily discounted. Simple appreciation of the fact that hypnosis is not a mystical, magical procedure to be accomplished in a moment's time, but a psychological phenomenon resulting from the interaction of two personalities, will make apparent that time often is an important element. Lack of such appreciation often accounts for the failure of otherwise well-planned hypnotic work.

Another type of misstatement is exemplified on page 52, where the author gratuitously supplies the misinformation that 25 per cent of all patients treated with metrazol suffer from spinal-column fractures as a consequence. In the same irresponsible fashion the author indulges (page 88) in the following uncontrolled speculation:

"... the kleptomaniac, and the pyromaniac are really working under a posthypnotic suggestion—minus the hypnotist. They act exactly in the same way as if they had been hypnotized and given their instructions in the trance. As a matter of fact, we will see that they *have* been hypnotized at some time in their life and have been given the suggestion in question. The fact that no hypnotist was involved, that they may never have seen a hypnotist in all their life, we will see, has no bearing whatsoever on the case."

Obviously, in such statements, the author is trying to draw an analogy, but he succeeds only in asserting a false identity. Nor is this the only instance where intended analogies become simple assertions of identity. Psychotic symptomatology, hallucinatory experiences, and criminalistic behavior are naïvely "explained" as hypnotic phenomena. From such uncritical writing the layman can acquire only further misinformation.

One final incredible instance of the author's unwarranted treatment of his subject may be cited. Discussing the highly disputed question of hypnotically induced crime, he declares (page 199): "Yet, strange to say, most good subjects will commit murder. In the writer's opinion there can be very little doubt on this score." Although the subsequent discussion minimizes this assertion, what is the layman to think when he is so dogmatically informed that "most good subjects" can be transformed from presumably normal persons into serious criminals by carefully worded suggestions? Concerning desired transformations of people by intelligent, capable hypnotic psychotherapy, however, the author is much more reasonable in his statements.

A few comments on individual chapters may be offered. In discussing the induction of hypnosis, as has been mentioned above,

the author places great emphasis upon theatrical time-limited techniques such as are employed in vaudeville or are illustrated in comic strips, because, as he explains, such techniques "get results." These results, if the reader is to judge from the illustrative material cited, are in the main limited to melodramatic forms of behavior. Inadequate, and then usually indirect, recognition is given to the fact that hypnosis causes profound alterations in the individual's psycho-physiological functioning for which time and systematic suggestion are required rather than sudden, impressive, dramatic commands which disregard the personality and the experiential background of the subject.

It is true that trances can be induced by vaudeville technique; but, as the experienced hypnotist knows, the results of such trances are as superficial and transient as are many religious conversions secured at highly emotional revivals—conversions that tend to vanish overnight because they are transient momentary performances which do not become an integrated part of the personality experience. Nevertheless, throughout the chapter the careful reader can note that the author unquestionably has a good appreciation of his subject despite the superficiality of his discussion.

The chapter on common hypnotic phenomena fails to present to the reader any systematic account of such phenomena. Instead, it is a curious mixture of history, theory, and speculation, with some discussion, usually inadequate and often misinformative, of a few dramatic instances of trance behavior. Actually, this same comment with some slight variation can be made on all of the chapters.

The chapters on the criminal use of hypnosis and on the medical uses of hypnosis likewise show no effort to present any orderly, systematic evaluation of available information. They abound with speculations and dogmatic assertions, often contradictory in character, and there is little of value to help the lay reader formulate any intelligent understanding of these topics.

Three other chapters warrant special mention. The first of these is Chapter IV, *Some Curious States in Everyday Life Which Are Due to Hypnotism*. With this heading to direct his thinking and understanding, the reader is offered an unorganized discussion of dissociation, compulsions, psychotherapy, spiritism, multiple personality, hysteria, and other forms of behavior. To formulate any intelligent concepts from such a medley of topics so briefly treated, the reader needs professional training.

The two other chapters concern the use of hypnosis in warfare and "this man Hitler." Little needs to be said except that in these chapters the author runs riot with armchair speculation and long-

distance diagnosis. Hypothetical experiments are suggested from which the author divines what would be the actual experimental results; conversations are fabricated and then discussed to show, on the basis of their imaginary content, exactly what could be accomplished for military purposes under certain hypothetical conditions. Perhaps, as the author hints in his preface, he has actual information to substantiate some of these ideas; but he is not warranted in presenting them to the reader without some factual basis to substantiate them.

In brief, the author has done hypnosis a serious disservice by presenting this book to the lay public.

MILTON H. ERICKSON.

Eloise Hospital, Eloise, Michigan.

CONVULSIVE SEIZURES: HOW TO DEAL WITH THEM. By Tracy Putnam, M.D. Philadelphia: J. B. Lippincott Company, 1943. 168 p.

Dr. Putnam's purpose in presenting this pocket-sized manual is to provide patients and their families with the content of an extended consultation on convulsive disorders. The book is written in a strikingly clear, nontechnical style, and gives in essence the clinical neurologist's approach to the cause, treatment, and outlook for control of epileptic disorders. With masterful condensation, Dr. Putnam has translated the established facts and concepts concerning seizure disorders into simple and practical "What to do and how" steps for the patient, the bystander, and all interested laymen, both when the attack occurs and afterward. Electroencephalography and an explanation of the action of the newer anticonvulsant drugs are given the prominent place they have earned in modern diagnosis and treatment. In this connection it may recalled that the first report on the effectiveness of phenytoin sodium was made by Drs. Putnam and Merritt in 1937.

Although the fundamental approach is the same, there are a few minor differences between the present streamlined manual and the first book on convulsions for the general public written by Dr. William Lennox two years before. The physician and others scientifically trained will find more of the historical background and research material in *Science and Seizures* than in the present book. The popular appeal of Dr. Putnam's book is enhanced by a number of charts and illustrations, one of which is an interesting elaboration of Dr. Lennox's seizure-threshold diagram. Migraine or "headache seizures," meriting a separate section in Dr. Lennox's book, receive mention in only one sentence in *Convulsive Seizures*.

Absence of instruction in the procedures outlined in this book con-

tributes greatly to the inadequate, hit-and-miss, even harmful self-treatment that is practiced by so large a proportion of extramural patients with seizures. Any physician who still dismisses epileptic patients with nothing more than a prescription for a sedative certainly needs to extend his own horizon by reading the book himself. A desirable new feature is the practical outline given for keeping much-needed interval records at home. A special chapter primarily intended for lawyers and legislators gives a brief survey of the chaotic condition of laws in this country relating to epileptiform disorders.

This book should be required reading for every intelligent patient with convulsive seizures, as well as all others who have an interest in the care of such patients. It will prove especially valuable to parents faced with the care of children with convulsions.

LEONARD E. HIMLER.

University of Michigan, Ann Arbor.

THE THERAPY OF THE NEUROSES AND PSYCHOSES. Second edition.
By Samuel Henry Kraines, M.D. Philadelphia: Lea and Febiger,
1943. 567 p.

This second edition of Dr. Kraines's book has been expanded by the inclusion of new material on the subject of schizophrenia, and by the addition of chapters on shock therapy, the organic psychoses, and neuropsychiatric states induced by the war. In the first part of the book, considerable space is given to psychopathology. There are chapters on the fundamental psychology of the psychoneurosis, psychoneurotic symptoms expressed primarily by psychologic factors, psychoneurotic symptoms due to disturbance in the autonomic nervous system, sex drives, and stress as a determining factor. Dr. Kraines's style is very readable and his discussion of the various factors that enter into psychotherapy is good. There is a chapter devoted entirely to psychosomatic diseases and their treatment as well as one on shock therapies.

To this reviewer, the weakness of the book lies in the fact that the author seems to have leaned over backward in an effort to avoid identifying himself with some of the commonly used systems of thought in psychiatry. We admit that eclecticism may have its place, and a book that is a mere compilation of the opinions of others can be tedious. Nevertheless, for a teacher in the field of psychiatry, there would seem to be some value in allying himself a little more closely with one of the disciplines of thought that have been in use for the last forty or fifty years, such as Meyer's psychobiology or Freud's psychoanalysis. Even though the book contains a foreword by Dr. Adolf Meyer, little credit is given to him in the

book for the use of some of his concepts. In the same way many of the concepts of psychoanalysis are used freely, while in the same breath the author explains that he rejects what he calls the superstructure of psychoanalysis and also rejects psychoanalysis as a therapeutic tool.

Except in chapter four, there are in the whole book hardly any references to other writers. Practically all the references throughout the rest of the book are to Dr. Kraines's own writings and opinions. The chapter on psychosomatic medicine, for instance, is amazingly lacking in references to the wealth of work that has been done in this field by many authors, particularly those of the psychoanalytic school. The serious student in psychiatry will certainly wonder why the author has apparently so little respect for his fellow workers in the field. Moreover, if he takes Dr. Kraines seriously, he will have a psychological barrier to leap in order to pass on from Dr. Kraines's book to some of the more classical treatises on psychiatric thought, since Dr. Kraines has not deigned to put his approval upon them.

The user of this book will get some idea of psychopathology and some helpful suggestions on the treatment of the neuroses and psychoses and allied states, but since Dr. Kraines has seen fit to choose what he likes from psychiatric literature and call it his own, and to reject what he could not himself accept, regardless of its author's standing in the field of psychiatry, the end result will be that the reader will have nothing more or less profound or scientific than Dr. Kraines's personal adaptation of psychiatric thinking. The more sophisticated psychiatrist can make his own judgments on the value of this in each chapter, but unfortunately the beginner cannot do likewise.

In spite of the above criticism, there are some excellent pages on the various types of therapy. The reader should get the "feel" of the psychotherapeutic approach to the patient, and if he combines any psychological intuition at all with Dr. Kraines's text, he should be able to achieve considerable success with his patient. One gets the impression that Dr. Kraines is himself a practical and capable psychotherapist.

O. SPURGEON ENGLISH.

Temple University, Philadelphia.

INTRODUCTION TO GROUP THERAPY. By S. R. Slavson. New York: The Commonwealth Fund, 1943. 352 p.

Mr. Slavson has written a very interesting report of the work in group therapy carried on by the Jewish Board of Guardians in New York City. To quote the introduction, "The Jewish Board of

Guardians is a social service agency rendering a child guidance service to children presenting problems of personality. . . . The material is based on records of 750 children between the ages of nine and eighteen and of fifty-five groups, each functioning for about two years."

The work makes a definite contribution to the effort to reach, through what might be called "situational" therapy, a larger number of children than can be treated with individual psychotherapy.

The groups are play or work groups of children of similar ages who show difficulties in social adjustment. These groups meet once a week and do manual or craft work or go on expeditions under the leadership of one older person.

Mr. Slavson compares these groups to a family group. Obviously, they are dissimilar to family groups, as the children are mostly of the same ages. Anna Freud has called attention to this dissimilarity to family life in groups of young children in a residential nursery such as the Hampstead Nursery.¹ She points out that, instead of having a place in the group as older or younger children, they are exposed to children of their own age, who are as unsocial in their reactions as the others in the group. Mr. Slavson's group differs from a residential group in that the children are in their own or foster homes and are in the therapy group for only a few hours each week.

In attempting to evaluate treatment, one must ask, "What can one expect to accomplish in therapy in a group?" The groups described by Mr. Slavson give opportunity for direct observation of the individual's behavior in a certain set-up. The child is enabled to act out a part of his conflict against his companions, who are thus sibling substitutes, and some responses against the leader as a substitute for parents, teachers, and others in authority.

Mr. Slavson stresses the "neutrality" of the leader and his passivity. What the leader really does, in the incidents related in the book, is to react in a manner as dissimilar as possible from the way that the parents and other adults in authority have reacted to the child in the past. This means that the leader does not meet aggression with aggression; he does not interfere unless actually forced to in conflicts between group members; he does not give orders or require work or conformance. The child is left free to choose his work, to determine how much or how little he will do. This removes, as a further incentive to undesirable behavior, the response that the child has met in the past. It brings him face to face with a new

¹ See the Freud-Burlingham report of July, 1943, issued by the Foster Parents' Plan for War Children, 55 West 42nd St., New York City.

line-up in the situation because he does not receive the libidinally charged response he has formerly elicited.

Now what does this accomplish? It allows the child the direct living out of a certain amount of aggression. It offers him a certain amount of sublimation in the work he does. The situation is eased for him; he learns to get more satisfaction from the tolerance and understanding shown him, and can, therefore, mitigate his aggression. This does not mean, however, that the conflict has been brought into his conscious mind as such, or that his ego has been allowed to "work over" the instinctual needs and to learn to handle them in a different way. Any deep-seated conflict remains untouched by such situational therapy.

The leader contributes other positive factors to the situation. He offers acceptance in spite of aggression, he gives understanding, and he shows recognition of achievement. These are powerful positive factors in the life of a badly adjusted child who has felt rebuff, aggression, punishment, and nagging. They increase the child's belief in himself and allow him to taste success and recognition. Even though the leader does not directly intervene in fights between members of the group, his mere presence has an effect. This positive relationship to the leader, though not stressed by the author, is, I think, one of the main reasons for positive results. Aichhorn, in his book, *Wayward Youth*, stresses this factor of the positive feeling for the leader as the main motivating force in the modification of behavior.

Some of the theoretical discussions and explanations in the book show a somewhat confused grasp of psychoanalytical theory. The author is not clear about the basis of neurotic conflict as a conflict between the demands of the instinctual drives, the ego, and the super-ego. He is not clear either about the formation of the super-ego.

The book, however, makes a definite contribution as a stepping-stone to a further program for such work with children.

JULIA DEMING.

Boston, Massachusetts.

NOTES AND COMMENTS

Compiled by

MARY VANUXEM, PH.D.

New York State Committee on Mental Hygiene of the
State Charities Aid Association

NATIONAL COMMITTEE FOR MENTAL HYGIENE ESTABLISHES RESEARCH FUND IN PSYCHOSOMATIC MEDICINE

The National Committee for Mental Hygiene has announced the establishment of a fund for research in psychosomatic medicine, dealing with the relationship between the emotions and bodily illness.

Dr. George S. Stevenson, Medical Director of the Committee, under whom the fund will be administered, stated that the purpose is to stimulate and subsidize study of the psychosomatic aspects of the diseases chiefly responsible for disability and death.

The Committee has named as director of the fund Dr. Edward Weiss, professor of clinical medicine at the Temple University School of Medicine, Philadelphia, who, with Dr. O. Spurgeon English, professor of psychiatry at Temple, is author of the book *Psychosomatic Medicine*, published in 1943.

Projects suggested as fields fruitful for research will be considered by the following committee: Dr. Charles M. Aldrich, head of the Department of Pediatric Research, Mayo Clinic, Rochester, Minn.; Dr. Franz Alexander, Director, Institute of Psychoanalysis, Chicago; Dr. Stanley Cobb, professor of neuropathology, Harvard Medical College, Cambridge, Mass.; Dr. George E. Daniels, attending psychiatrist, Vanderbilt Clinic, New York City; Lt. Col. William Menninger, head of the Psychiatric Division, United States Army, Medical Department, Surgeon General's Office, Washington, D. C.; and Dr. John Romano, professor of psychiatry, University of Cincinnati Medical School.

Dr. Stevenson stated that the establishment of the research fund was due in considerable part to the interest and efforts of a member of the Board of Directors of The National Committee for Mental Hygiene. The fund begins with a nucleus of \$10,000 which, it is expected, may be increased later in the light of developments and results.

Dr. Weiss, director of the fund, stated recently that emotional factors are involved in about one-third of the patients who consult physicians. Heretofore research in this field has been limited to a few centers inadequately financed.

"It is hoped," said Dr. Weiss, "that the establishment of the fund under the auspices of The National Committee for Mental Hygiene will stimulate the development of the field of medicine which has such an important bearing upon the many causes of disability and death.

"Psychosomatic medicine refers to the psyche—the mind—and the soma—the body—in other words, the relationship between the emotions and bodily illness," he continued. "It is a new term, but it describes an approach to medicine as old as the art of healing itself. Physicians have always known that the emotional life had something to do with illness, but in the last hundred years, largely due to the development of the laboratory sciences in medicine, there has been a separation of disease from the psyche of man and its consideration as only a disorder of organs and cells. Remarkable developments have occurred during this period of laboratory ascendancy, but the emotional side of illness has been almost entirely neglected.

"Clinical studies, however, show that between the small number of obviously psychotic persons whom a physician sees and a larger number of patients who are sick solely because of physical disease, are a vast number of sick people who are not 'insane' and yet who do not have any definite bodily disease to account for their illness. It is reliably estimated that about a third of the patients who consult a physician fall into this group. These are the so-called 'functional' problems of medical practice, comprising such disorders as nervous indigestion, nervous heart action, nervous cough, headache and constipation, and a host of other such ailments.

"Approximately another third of the patients who consult a physician have symptoms that are in part dependent upon emotional factors, even though organic findings are present. This second group is even more important than the first from the standpoint of diagnosis and treatment. These psychosomatic problems are often very complicated and, because serious organic disease may be present, the psychic factor is capable of doing more damage than in the first group. This phase of the subject applies especially to organic heart disease and has an important relationship to the high cost of medical care.

"A third group comprises a group of disorders generally considered wholly within the realm of 'physical disease,' such as migraine, asthma, essential hypertension, and peptic ulcer. Psychosomatic medicine is much interested in these disorders because it believes that the psychic factor may be of great importance in their causation and, even more importantly, in their management.

"Thus it is seen that psychosomatic medicine has a wide field of application. Nevertheless, research in this newly developing field of medicine has been carried on in only a few centers and without adequate financial support. Techniques of psychosomatic investigation,

formerly lacking, are now available, and general medicine, largely due to the stimulus provided by military experience, is showing a greater interest in psychosomatic medicine.

"The large percentage of men turned down by the selective service process because of psychoneurosis and the even greater percentage discharged from military service for the same reason, together with the large number of psychoneurotic casualties from the war zones, have made thousands of physicians aware of the great importance of psychological factors in producing disturbances in bodily function.

"World War I saw the establishment of psychiatry on a firm scientific basis; World War II is seeing its final integration into general medicine—in other words, psychosomatic medicine."

**MRS. ALBERT D. LASKER NEW SECRETARY OF THE NATIONAL
COMMITTEE FOR MENTAL HYGIENE**

Announcement has been made of the election of Mrs. Albert D. Lasker, of New York, as Secretary of The National Committee for Mental Hygiene. Mrs. Lasker succeeds the late Clifford W. Beers, who, after founding the Committee in 1909, served as its secretary from then until his retirement in May, 1939, and thereafter as honorary secretary until his death in July, 1943.

Mrs. Lasker, who accepted the secretaryship as a voluntary service because of her deep interest in mental health, is a native of Watertown, Wisconsin. She graduated from Radcliffe College in 1923 and later studied at Oxford University. She has been interested in mental hygiene for many years. In addition to being Secretary of The National Committee for Mental Hygiene, she is also a member of its board of directors; a member of the Board of Trustees of the Institute of Psychoanalysis, Chicago; and a trustee of the Menninger Foundation, Topeka, Kansas. She is Secretary of the Board of Directors of Group Health Coöperative, New York; a member of the Board of Trustees and of the Executive Committee of the Planned Parenthood Federation; and a member of the Advisory Committee of the Museum of Modern Art, New York.

**ARMY REGULATIONS RELATIVE TO DISCHARGE OF ENLISTED MEN FROM
ACTIVE SERVICE**

Since Pearl Harbor, the question of the discharge of enlisted men from active service has become a topic of interest to many persons. The average civilian, however, does not realize that there are twelve different types of discharge issued by the War Department. The

following digest of Army Regulations 615-360 describes briefly the conditions under which each of these types of discharge is given:

I. Completion of Service.—Up to December 7, 1941, the commonest type of discharge was the one given for completion of service, but since that date all terms are extended to cover the duration and to continue for six months beyond the termination of the war. When a man had completed his term of service, he was discharged unless (1) awaiting trial or the result of trial; (2) retained in service under the authority of the Secretary of War; (3) awaiting discharge under certificate of disability; or (4) retained in service with his own consent to undergo medical care or hospitalization.

II. Disability.—According to army regulations, "no man will be separated from active service because of disability, unless the Government can obtain no useful service from him." When a man is found to be disqualified for service, he is obliged to be examined by a board of medical officers convened by the commanding officer of a general-hospital station or unit. These officers are required to make a critical examination of the man, and must note fully, in the certificate of disability for discharge, the origin of the disability and describe particularly the disability, wound, or disease. An honorable discharge is awarded.¹

III. Purchase.—In peace time, the President may, as he deems wise, permit an enlisted man to purchase his discharge. In order to do this, the man must have served at least one year. The price varies from \$170.00 down to \$15.00, depending upon the location of the station and the length of time the man has served. It is not the policy, however, of the War Department to permit a man to purchase his discharge (1) if there is any special reason to the contrary; (2) if he offers a trifling reason or no reason at all in support of his application; (3) if he desires his discharge in order to reënlist in some other organization; or (4) if he has graduated from a special service school during the enlistment which he is serving. If his application is granted, he is given an honorable discharge.

IV. Minority.—It frequently happens that boys under eighteen have misrepresented their ages and either have enlisted or have been inducted. "The Secretary of War shall discharge from the military service with pay and with the form of discharge certificate to which the service of each after enlistment shall entitle him, all enlisted men under the age of eighteen on the application of either of their parents or legal guardian." No minor, however, may be discharged on his own application. Evidence of age is required for each application. The minor will receive the form of discharge certificate to which the

¹ A white certificate indicates honorable discharge; a blue certificate other types of discharge, except dishonorable discharge.

service rendered will entitle him. The specific reason for discharge will be entered on the discharge certificate—for example, minority.

V. Dependency.—If the death or disability of a member of the family of an enlisted man should occur after his enlistment and the members of his family become dependent upon him for support, this man may, at the discretion of the Secretary of War, be discharged from the service. Before this discharge occurs, however, the following evidence, supported by affidavits, must be submitted: (1) the enlisted man's presence at home is necessary for the support or care of members of his family; (2) this condition has arisen due to death or disability occurring in the enlisted man's family since his enlistment or induction; and (3) the discharge of the enlisted man is necessary to prevent or to relieve destitution and the necessity thereof is extreme. The appropriate discharge is issued.

VI. Fraudulent Enlistment.—No enlisted man will be discharged because of fraudulent enlistment except by reason of (1) concealment of desertion from the Navy, Marine Corps, or Coast Guard; (2) concealment of conviction by civil court of certain serious crimes, or concealment of a sentence in excess of a year in a prison or penitentiary; (3) concealment of the fact that he is on parole from a penal institution or probation from any court or is on a suspended sentence. An enlisted man discharged for fraudulent enlistment will be given a blue certificate of discharge.

VII. Desertion.—“The commanding general of the service command or other officer exercising general court-martial jurisdiction may order the discharge without trial because of desertion or physical unfitness after return to military control of a deserter who is physically unfit for service and whose trial is not barred” by the Thirty-ninth Article of War. The term “physical unfitness” is construed to mean (1) those medical or surgical conditions that permanently incapacitate for further military service and (2) those cases of mental deficiency and constitutional psychopathy that obviously cannot be adapted to military service. Blue certificates of discharge will be used for all discharges under this heading.

VIII. Inaptness or Undesirable Habits or Traits of Character.—When an enlisted man (1) is inapt, (2) does not possess the required degree of adaptability for military service after repeated attempts have been made to reclassify and reassign him, (3) gives evidence of habits or traits of character (not connected with either physical or mental disabilities) that render his retention in the service undesirable and his rehabilitation impossible, (4) is disqualified for service, physically or in character, through his own misconduct and cannot be rehabilitated so as to render useful service, his company or detachment commander will report the facts to the commanding officer.

The commanding officer will convene a board of three, if possible, one of whom will be a medical officer. If the man is discharged, his certificate will read, "Section VIII, AR 615-36, not eligible for reënlistment or induction." His discharge will be blue, unless he is discharged for inaptitude or lack of required adaptability.

IX. Conviction by Civil Court.—The commanding general of a service command or other designated officers are authorized within their discretion to discharge an enlisted man from the service if it is shown that said man has been convicted by a civil court of an offense which would indicate that he is not a suitable person to associate with enlisted men. Conviction for such crimes as treason, murder, rape, kidnaping, arson, any crimes of sex perversion, and illegal dealing in narcotics and habit-forming drugs, would come under this category. He would also be discharged if he has been convicted of any offense and sentenced to confinement in excess of a year and a day in a prison or penitentiary. If he is on parole from a penal institution, on probation from a civil court, or under a suspended sentence not involving probation, he will be discharged. If, however, parole, probation, or suspended sentence has been terminated or suspended for a period of military service, the enlisted man will not be discharged.

An enlisted man discharged on account of conviction by a civil court will be given a blue certificate of discharge from the Army of the United States.

X. Convenience of the Government.—In general, this discharge is given by the authority of the Secretary of War only. It may be given either in an individual case or by an order applicable to all cases of a class specified in the order. All requests are based either (1) upon the enlisted man's importance to national health, safety, or interest, or (2) upon claim that the trainee was erroneously classified, should not have been inducted, and did not have an opportunity to present his case to an appeal board. Unless otherwise directed, the enlisted man will be given an honorable discharge from the Army of the United States.

XI. Writ of Habeas Corpus.—The discharge of an enlisted man from the army may be ordered by a United States court or a justice or judge thereof. If the War Department or the Department of Justice decides not to appeal the case, the enlisted man will be given an honorable discharge by his organization commander.

XII. Dishonorable Discharge.—"An enlisted man will be dishonorably discharged pursuant to a sentence of a court martial or a military commission." Fraudulent enlistment or induction also comes under this type of discharge. A dishonorable discharge is a complete expulsion from the army and covers all unexpired enlistments.

BUTLER HOSPITAL CELEBRATES ITS CENTENARY

On May 4, Butler Hospital, of Providence, Rhode Island, celebrated "the completion of a century of service."

The spirit in which the hospital observed its hundredth birthday was well expressed by the president of its board of trustees, Mr. Walter A. Edwards, in his Foreword to the Centennial Volume issued in honor of the occasion:

"The celebration of an institution's centenary ought to be an occasion for grateful commemoration of the achievement of those who founded and developed it. But the debt of a later generation to earlier generations is not discharged by mere commemoration. The living owe it to the dead to adapt the latter's achievement to new conditions and to impart to it a continuing growth; for otherwise the achievement will prove as mortal as those who wrought it. Therefore, at the end of a century, or at any other moment of time, the present's debt to the past cannot be paid; only in the future can payment be made."

Acknowledgment of the hospital's debt to the past was made in the Centennial Volume, *A Century of Butler Hospital, 1844-1944*, an attractive brochure beautifully printed and illustrated. But the addresses at the centennial celebration on May 4 dealt, not with past achievements, but with problems of the present and of the future. Dr. Edward A. Strecker, of Philadelphia, spoke on "The Contribution of Psychiatry to Democratic Morale"; Dr. Gregory Zilboorg, of New York City, on "Psychiatric Problems in the Wake of the War"; and Dr. Karl A. Menninger, of the Menninger Foundation, Topeka, Kansas, on "The War Against Fear and Hate." Miss Elizabeth Bixler, of the Yale University School of Nursing, discussed "The Contribution of Psychiatric Nursing to Nursing Education." And Dr. Alan Gregg, Director of the Division of Medical Science of the Rockefeller Foundation, presented a paper on "The Place of the Endowed Hospital in the Future."

According to the "Historical Note" included in the printed program, Butler Hospital was not only the first mental hospital in the state of Rhode Island, but the first hospital of any kind. Although its official existence dates from 1844, its history goes back to the will of Nicholas Brown, of Providence, who died in 1841, leaving a bequest of \$30,000 "towards the erection and endowment of . . . a retreat for the Insane."

In 1844 the state legislature, acting upon the petition of a group of citizens of Providence, granted a charter for the establishment of the "Rhode Island Asylum for the Insane." And shortly thereafter a prominent merchant of Providence, the Honorable Cyrus Butler,

agreed to contribute \$40,000 toward the establishment of such an institution, providing an equal sum were raised by subscriptions, so that \$50,000 could be set aside as a permanent endowment fund. These conditions were met, and in the fall of 1844 a tract of one hundred and fourteen acres of land was bought for the sum of \$6,000. As an expression of appreciation of Mr. Butler's aid, the trustees of the hospital voted to name the new institution "The Butler Hospital for the Insane."

Dr. Isaac Ray, Superintendent of the Maine State Asylum in Augusta, was engaged as the first Superintendent of Butler Hospital, and he and Dr. Luther V. Bell, Superintendent of McLean Asylum near Boston, whom the trustees had engaged as consultant, worked out the design of the buildings which still comprise the nucleus of the hospital. Ground was broken for the building in the fall of 1846, and on December 1, 1847, Butler Hospital opened its doors to receive its first patients.

Originally designed to accommodate about one hundred patients, the hospital to-day has accommodations for one hundred and seventy-five, with all the clinical and laboratory facilities of a modern hospital, a large and fully equipped gymnasium, a hobby shop, an industrial shop, a conservatory, and residences for superintendent and doctors.

For half a century the hospital has maintained a school of nursing, and at present admits yearly over two hundred affiliating student nurses from fourteen general hospitals for a course in psychiatric nursing.

In its hundred years of existence the hospital has had six superintendents, of whom three—Dr. Isaac Ray, Dr. G. Alder Blumer, and the present superintendent, Dr. Arthur H. Ruggles—have been presidents of the American Psychiatric Association.

No account of the hospital would be complete without mention of the fact that the board of trustees in whose hands its administration lies have maintained an unbroken record of weekly visits throughout the wards for the entire century of its existence—a record, as the centennial program states, "perhaps without parallel in the annals of American medical institutions." Many of the trustees are carrying on a family tradition of service to the hospital. One of the members of the board, John Nicholas Brown, Chairman of the Centennial Committee, is a great-grandson of the Nicholas Brown whose bequest was originally responsible for the founding of the hospital.

BUTLER HOSPITAL CELEBRATES ITS CENTENARY

On May 4, Butler Hospital, of Providence, Rhode Island, celebrated "the completion of a century of service."

The spirit in which the hospital observed its hundredth birthday was well expressed by the president of its board of trustees, Mr. Walter A. Edwards, in his Foreword to the Centennial Volume issued in honor of the occasion:

"The celebration of an institution's centenary ought to be an occasion for grateful commemoration of the achievement of those who founded and developed it. But the debt of a later generation to earlier generations is not discharged by mere commemoration. The living owe it to the dead to adapt the latter's achievement to new conditions and to impart to it a continuing growth; for otherwise the achievement will prove as mortal as those who wrought it. Therefore, at the end of a century, or at any other moment of time, the present's debt to the past cannot be paid; only in the future can payment be made."

Acknowledgment of the hospital's debt to the past was made in the Centennial Volume, *A Century of Butler Hospital, 1844-1944*, an attractive brochure beautifully printed and illustrated. But the addresses at the centennial celebration on May 4 dealt, not with past achievements, but with problems of the present and of the future. Dr. Edward A. Strecker, of Philadelphia, spoke on "The Contribution of Psychiatry to Democratic Morale"; Dr. Gregory Zilboorg, of New York City, on "Psychiatric Problems in the Wake of the War"; and Dr. Karl A. Menninger, of the Menninger Foundation, Topeka, Kansas, on "The War Against Fear and Hate." Miss Elizabeth Bixler, of the Yale University School of Nursing, discussed "The Contribution of Psychiatric Nursing to Nursing Education." And Dr. Alan Gregg, Director of the Division of Medical Science of the Rockefeller Foundation, presented a paper on "The Place of the Endowed Hospital in the Future."

According to the "Historical Note" included in the printed program, Butler Hospital was not only the first mental hospital in the state of Rhode Island, but the first hospital of any kind. Although its official existence dates from 1844, its history goes back to the will of Nicholas Brown, of Providence, who died in 1841, leaving a bequest of \$30,000 "towards the erection and endowment of . . . a retreat for the Insane."

In 1844 the state legislature, acting upon the petition of a group of citizens of Providence, granted a charter for the establishment of the "Rhode Island Asylum for the Insane." And shortly thereafter a prominent merchant of Providence, the Honorable Cyrus Butler,

agreed to contribute \$40,000 toward the establishment of such an institution, providing an equal sum were raised by subscriptions, so that \$50,000 could be set aside as a permanent endowment fund. These conditions were met, and in the fall of 1844 a tract of one hundred and fourteen acres of land was bought for the sum of \$6,000. As an expression of appreciation of Mr. Butler's aid, the trustees of the hospital voted to name the new institution "The Butler Hospital for the Insane."

Dr. Isaac Ray, Superintendent of the Maine State Asylum in Augusta, was engaged as the first Superintendent of Butler Hospital, and he and Dr. Luther V. Bell, Superintendent of McLean Asylum near Boston, whom the trustees had engaged as consultant, worked out the design of the buildings which still comprise the nucleus of the hospital. Ground was broken for the building in the fall of 1846, and on December 1, 1847, Butler Hospital opened its doors to receive its first patients.

Originally designed to accommodate about one hundred patients, the hospital to-day has accommodations for one hundred and seventy-five, with all the clinical and laboratory facilities of a modern hospital, a large and fully equipped gymnasium, a hobby shop, an industrial shop, a conservatory, and residences for superintendent and doctors.

For half a century the hospital has maintained a school of nursing, and at present admits yearly over two hundred affiliating student nurses from fourteen general hospitals for a course in psychiatric nursing.

In its hundred years of existence the hospital has had six superintendents, of whom three—Dr. Isaac Ray, Dr. G. Alder Blumer, and the present superintendent, Dr. Arthur H. Ruggles—have been presidents of the American Psychiatric Association.

No account of the hospital would be complete without mention of the fact that the board of trustees in whose hands its administration lies have maintained an unbroken record of weekly visits throughout the wards for the entire century of its existence—a record, as the centennial program states, "perhaps without parallel in the annals of American medical institutions." Many of the trustees are carrying on a family tradition of service to the hospital. One of the members of the board, John Nicholas Brown, Chairman of the Centennial Committee, is a great-grandson of the Nicholas Brown whose bequest was originally responsible for the founding of the hospital.

THE AMERICAN PSYCHIATRIC ASSOCIATION ENTERS ITS SECOND CENTURY

The congratulations and good wishes of all friends of psychiatry were with the American Psychiatric Association in its annual meeting this year, for with this meeting the association passed its first hundred-year milestone and entered upon its second century.

The meeting was held May 15-18 in Philadelphia, where the association was organized in 1844; and one of the addresses of welcome was given by Mr. Franklin B. Kirkbride, son of Dr. Thomas P. Kirkbride, Superintendent of the Pennsylvania Hospital for Mental Diseases, who was the first secretary and the second president of the association.

The historical note entered also into the message of welcome from the outgoing president of the association, Dr. Edward A. Strecker, of Philadelphia, which appeared in the program:

"One hundred years ago," wrote Dr. Strecker, "thirteen wise and far-seeing psychiatrists met in this city in a house still standing on the grounds of the Pennsylvania Hospital. They formed this Association, now grown to a membership of three thousand, one hundred, and twenty-five. Originally, the superintendents of thirteen hospitals, eleven of which are represented at this Centenary Meeting, were charter members of the Association. In the United States, there are now five hundred and eighty-six modern mental hospitals."

"It is altogether fitting and proper that this Centenary Meeting should be held in Philadelphia, and that the city which was the birthplace of the Nation should also have been the birthplace of this Association, which has done so much to free Psychiatry from the bondage of ignorance and superstition and make it a free, humanitarian, and scientific discipline."

It is impossible, in the space available, to make more than brief mention of the wide range of subjects covered in the various section meetings. As was to be expected, psychiatry and the war was the outstanding topic. One whole section was devoted to "Psychiatry and the United States Army," another to "Psychiatry and the U. S. Navy," another to "Morale" and still another to "Rehabilitation." But there were few sessions that did not include at least one paper on some psychiatric aspect of the war situation.

Several joint meetings were held—one with the American Society for Research in Psychosomatic Problems, one with the American Psychoanalytic Association, and one with the American Association on Mental Deficiency. There were also a number of round-table discussions, including one on "Civilian Utilization of War-Fostered Trends," one on "Group Psychotherapy," and one on "Industrial Mental Hygiene and Psychiatry."

The officers of the association for the coming year are: President, Dr. Karl M. Bowman, Director of the Langley Porter Clinic, of San

Francisco; president-elect, Dr. Samuel W. Hamilton, Mental Hospital Advisor, Division of Mental Hygiene, United States Public Health Service; secretary-treasurer, Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, Washington, D. C.

The 1945 meeting of the association will be held in Chicago, Illinois.

"The best of Prophets of the future is the Past." With a century of fine achievements behind it, the American Psychiatric Association has every reason to look forward with hope and confidence to its second hundred years.

SIXTY-EIGHTH ANNUAL MEETING OF THE AMERICAN ASSOCIATION ON MENTAL DEFICIENCY

In spite of war-time conditions, over 400 persons from 29 states, the District of Columbia, and several provinces in Canada attended the Sixty-eighth Annual Meeting of the American Association on Mental Deficiency, held in Philadelphia May 11-15.

The meeting was opened with addresses of welcome by Hon. Bernard Samuel, Mayor of Philadelphia; Hon. S. M. K. O'Hara, State Secretary of Welfare; and Dr. Eugene Pendergrass, President of the Philadelphia County Medical Society.

The program included discussions of mental defectives and the war, and of educational, psychological, medical, and social researches in the field of mental deficiency.

An interesting innovation was the devotion of an entire session to the subject "The Duties and Problems of Trustees." As far as can be learned, this was the first time that trustees of state, semi-state, and private institutions have had an opportunity to present their side of a very important question. The session was so successful that in all probability it will become an annual event.

At the president's dinner, the president, Dr. C. Stanley Raymond, gave an excellent address on "Retrospect and Prospect in Mental Deficiency." Two luncheons also were held, one addressed by Dr. Arthur H. Estabrook, Secretary of the Mental Hygiene and Public Health Division of the Public Charities Association of Pennsylvania, and the other by Dr. Temple Fay, professor of neuropsychiatry at Temple University, who gave a forceful and interesting talk on "Factors in Mental Deficiency."

The following officers were elected for the coming year: President, Dr. E. Arthur Whitney, Superintendent of Elwyn Training School, Elwyn, Pennsylvania; president-elect, Mabel A. Matthews, Director of the Mansfield-Southbury Social Service Department, Hartford, Connecticut; secretary-treasurer, Dr. Neil A. Dayton, Superintendent of Mansfield Training School and Hospital, Mansfield Depot, Con-

necticut; editor of the journal, Dr. Edward J. Humphreys, Assistant Superintendent of Coldwater State Home and Training School, Coldwater, Michigan.

The 1945 meeting of the association will be held in Cleveland, Ohio.

THIRTY-FOURTH ANNUAL MEETING OF THE AMERICAN PSYCHOPATHOLOGICAL ASSOCIATION

The thirty-fourth Annual Meeting of the American Psychopathological Association was held in New York City on June 9 and 10. One of the features of the meeting was a symposium on "Current Trends in Mental Disease," conducted by Joseph Zubin, of the United States Public Health Service, Sheepshead Bay Hospital, Brooklyn. The papers included one by Francis J. Braceland, Commander, M.C., U.S.N.R., who spoke on "Trends of Mental Disease in the Navy," and one by Emil Frankel, of the Division of Institutions and Agencies, Trenton, New Jersey, who discussed "Neuropsychiatric Screening of New Jersey Selective Service Registrants." Other speakers presented papers on mental-disease trends in various of the states and in the United States.

The evening meeting on June 9 was a joint session with the New York Society for Psychotherapy and Psychopathology.

Professor Ernest M. Ligon, of Union College, Schenectady, New York, was the guest of honor at the dinner meeting on June 10. He spoke on "The Direct Measurement of Combat Stability."

SECOND ANNUAL MEETING OF THE AMERICAN GERIATRICS SOCIETY

Realization of the fact that the United States is becoming more and more a middle-aged and elderly nation adds interest to the program of the American Geriatrics Society, which held its second annual meeting in New York City, June 8-10. The program included such titles as *The Aging Mind, Occupational Therapy and the Aging Person, The Aging Have a Future*, etc.

Discussing the subject of "Geriatric Practice," Dr. Malford W. Thewlis, of Wakefield, Rhode Island, warned of the danger in the use of certain words. "There are words which really kill patients," Dr. Thewlis said. "They dwell on them and shorten their lives by worry. 'Cancer' is the most dreaded word in the language. 'Tumor' is far gentler.

" 'Arthritis,' a ruthless word, cripples as many aged as the disease itself. 'Apoplexy,' or 'stroke,' is another terrifying word. 'Bright's disease' is another panicky word. 'Nephritis' is less sharp. One might better substitute: 'Blood pressure is somewhat above normal.'

"'Arteriosclerosis' is another frightening term. I seldom use it unless it seems absolutely necessary, or if I do, I remark that most elderly people have arteriosclerosis. Merciless words may shorten the lives of people already struggling with social and economic difficulties."

Other papers of special interest to the readers of MENTAL HYGIENE were the two presented at the dinner meeting—*Psychological and Psychopathological Aspects of Aging*, by Dr. Oskar Diethelm, psychiatrist-in-chief of the Payne Whitney Clinic, New York Hospital, and *Our Debt to the Aging*, by Captain William Seaman Bainbridge, Medical Corps, United States Naval Reserve—and two of the papers in the sessions on "Clinical Problems Associated with Aging"—*Occurrence and Treatment of Delirious Reactions in the Aging*, by Dr. Edwin J. Doty, of New York City, and *Functional Personality Disorders in the Aging*, by Dr. Edward B. Allen, of White Plains, New York.

The program included also visits to the Payne Whitney Clinic of New York Hospital and to the Polyclinic Hospital.

STATE SOCIETY NEWS

Connecticut

On May 12, the Connecticut Society for Mental Hygiene held its Fifth Annual Institute of Mental Hygiene in New Haven. The conference, which had been announced as "one of the initial community efforts to meet the need of returning soldiers," was devoted to the subject of "The Psychoneuroses."

"The Psychoneuroses in War Time" was the theme of the morning session, the speakers being Dr. Felix Deutsch, Director of the Psychiatry Clinic of Boston, and Dr. Florence Powdernaker, of the United States Public Health Service.

At noon the Connecticut Society for Mental Hygiene held its annual meeting, with a luncheon, and an address—*When the Soldier Comes Home*—by Dr. William B. Terhune, president of the society.

The afternoon meeting was divided into four sessions. The general topic, "Practical Aspects of Psychoneurosis," was discussed (1) in public health nursing, by Dr. Frederick C. Redlich, of the Department of Psychiatry and Mental Hygiene, Yale School of Medicine; (2) in social case work, by Dr. Felix Deutsch; (3) in employment, by Dr. Fred W. Dershimer, of the Medical Department of E. I. Du Pont de Nemours and Company; and (4) in the community, by Dr. Temple Burling, Medical Director of the Providence (Rhode Island) Child Guidance Clinic.

The conference was unusually well attended, the audience including not only those professionally interested, but many representatives of industry and of the general public.

The Waterbury Society for Mental Hygiene held its annual meeting on June 5. Dr. Howard W. Haggard, Director of the Laboratory of Applied Psychology, Yale University, was the speaker of the evening.

Iowa

The organization meeting of the Iowa State Society for Mental Hygiene was held in Des Moines on April 20. One hundred and twenty-five men and women, representing various professional, religious, and lay groups in the state, attended the meeting, at which a constitution and by-laws were adopted and the following officers elected for the coming year: President, Dr. Walter L. Bierring, Commissioner of the State Department of Mental Health, Des Moines; vice-presidents, Dr. Andrew H. Woods, of Iowa City, and Mr. Jim O. Henry, Chairman of the Pottawattamie County Board of Supervisors, Council Bluffs; secretary and treasurer, Dr. Wilbur R. Miller, Acting Director of the Psychopathic Hospital, Iowa City; executive director, Dr. Norman D. Render, Superintendent of Clarinda State Hospital, Clarinda.

A board of fifty directors was also elected from the membership, and from this board an executive committee of twelve.

Membership in the society is open to all residents of Iowa, patrons contributing \$100 or more, regular members paying \$1.00 annual dues, honorary membership being conferred for distinguished service.

Massachusetts

The Massachusetts Society for Mental Hygiene assisted the Counseling and Educational Committee of the Governor's Rehabilitation Committee in arranging a series of lectures for employers and personnel department workers. The lectures, held at Ford Hall, Boston, with an enrollment of approximately 200 persons, were devoted to a discussion of the employment of veterans with neuropsychiatric discharge.

Missouri

The Missouri Association for Mental Hygiene announces the election of the following officers: President, Dr. Sydney B. Maughs, of St. Louis; vice-presidents, Dr. Sylvia Allen, of Kansas City, Ira Jones, of Jefferson City, and Dr. Ralf Hanks, of Nevada; secretary, Mrs. Elizabeth Lingenfelter, of Kansas City; treasurer, Mrs. Frank Dorsey, of Kansas City.

North Carolina

Under its new president, Junius Allison, the Asheville Mental Hygiene Society has organized an auxiliary to the health department's guidance clinic directed by Dr. Tom A. Williams, formerly of Washington, D. C.

At organization meetings in May, the following officers were elected: Chairman, Mr. C. L. Haymie, of the State Department of Rehabilitation; vice-president, Mrs. Eugene Taylor, of the Plonk School; secretary, Mrs. Richard McArdle. Committees were appointed on (1) purchase of books for the library, chairman, Miss Virginia Bryan, of Biltmore and Asheville Colleges; (2) organization of study groups, chairman, Mr. Leon Connor, of the senior high school; (3) procurement of better moving pictures, chairman, Mrs. Paul Rockwell, succeeded by Mrs. T. C. Autrey. The first and last of these have organized and reported successful undertakings, the cinema industry having promised those that are available of the films asked for. The book committee has already reported some dozen books purchased and fifteen presented by various individuals and organizations.

The auxiliary has been holding a series of weekly discussion meetings on various topics in the field of mental health. At the first, the subject of "Psychological Rehabilitation" was presented by Major Piazzin and Captain Rosenbloom, of Moore Hospital, Commander Mourot, Mr. Haymie, and others. The second meeting, on June 8, was the first of four on child development, to be held on the first Thursday of each month. The discussion was led by Drs. Richardson and Ward, the topic being "The Infant." "How to Choose a Career" was discussed at the third meeting, on June 22, the participants including members of the staff of Asheville and Biltmore Colleges, of the Y. M. C. A. and the Y. W. C. A. and of the private and public high schools, as well as representatives of the army air forces and of the W. S. Finance Division.

Among the subjects to be discussed at future meetings are the development of the pre-school child, backwardness in reading, defective speech, manners and ethics of adolescents (in home, school, and society), preparation for marriage and parenthood, mental hygiene of employees and employers, mental hygiene of Scout and camper, the rôle of the nursery school, and frustrations in home and school. There will also be reports on books read by members.

The City of Charlotte has established a veterans' reception and information center designed to coördinate community resources for ex-service men and women.

Plans for the center were first announced at the Charlotte Mental Hygiene Society's one-day institute, March 29, 1944. Dr. Luther

MENTAL HYGIENE

Woodward, of The National Committee for Mental Hygiene, addressed the luncheon meeting. His talk stressed the importance of community planning for veterans, and was the stimulus for immediate action.

Dischargees had been given psychiatric help in the Charlotte Mental Hygiene Clinic, but it was apparent that with over 600 ex-service men already returned to the county, the task could be met adequately only if all resources for prevention and treatment were coördinated. A center for information, and for direct reference of cases to the appropriate agencies would, Dr. Woodward suggested, avoid giving the veteran the "run-around" and insure the immediate service that is essential in preventing chronic mental-health problems.

The Charlotte Mental Hygiene Society was credited with initiating the plans for the center. Members of the society and of the clinic board are participating in the community-wide efforts to develop the center in accordance with demonstrated and expected needs.

Ohio

Dr. Frank F. Tallman, who has been Director of Mental Hygiene in the state of Michigan for the past two and a half years, is resigning to accept the position of Commissioner of Mental Diseases in the Ohio State Department of Public Welfare, Columbus.

There are fifteen hospitals for the mentally ill, feeble-minded, and epileptic in the Division of Mental Diseases which Dr. Tallman will supervise, with a population of about 27,000 patients. In addition to his work with the hospitals, Dr. Tallman will be responsible for a receiving-hospital program, and a state-wide program of mental hygiene.

Texas

The Eleventh Annual Meeting of the Texas Society for Mental Hygiene was held in Houston, March 2-3, with institutes beginning February 28. The Conference was sponsored jointly by the Hogg Foundation for Mental Hygiene, of the University of Texas, Galveston; the Houston Council of Social Agencies; and the Bureau of Mental Hygiene of Houston.

The meeting was exceptionally well attended; some 1,500 people were present at the sessions, and a group of 2,000 teachers participated in a special section organized for them.

Three new sections attracted great interest—one on mental hygiene and the community clinic; another on mental hygiene in business and industrial personnel; and the third on mental hygiene and the state-hospital program. There was not even standing room in the section on industrial personnel. As evidence of its interest, the Hughes Tool Company took out a \$50.00 membership in the state society; and its

personnel manager is taking the initiative in inviting other companies to do likewise.

The section on mental-hospital work, which Miss Clara Bassett, Director of the Social Service Department of the John Sealy Hospital, Galveston, helped to arrange, proved to be an excellent discussion of various types of mental-hospital work.

The dinner session, organized in honor of the hospital superintendents and the state board of control, served several purposes. It was the first time that the chairman of the board of control had attended one of the society's state meetings, and it was also the first time that all hospital superintendents had been present. Furthermore, it was the first time that they had had an opportunity to present to the public an outline of the state-hospital program and of its problems. Every ticket available was sold for this banquet meeting.

Another interesting feature of the conference, as reported by a vice-president of the Texas Society, Dr. Robert L. Sutherland, Director of the Hogg Foundation, was the series of institutes held in connection with it. "We are moving away," wrote Dr. Sutherland, "from the one- or two-day talk fest toward a working conference which will feature institutes and in-service training seminars. Several were organized this year for the first time, some of them beginning as early in the week as Monday. The maximum enrollment in all of these institutes was filled well in advance of the sessions."

Next year's conference is to be held in Austin, the second week-end in March.

Vermont

Miss Dorothy Smithson, of Rutland, has been appointed secretary of the Vermont Society for Mental Hygiene.

NEW PUBLICATIONS

Fortifying the Mind For War and For Peace is the title given by The National Committee for Mental Hygiene to its thirty-fourth annual report, issued in June. As the title indicates, the report stresses the services that the Committee is contributing to the furtherance of the war—notably, assisting Selective Service in preventing the induction of the mentally unstable into the armed forces and aiding governmental and community agencies in the psychiatric care and rehabilitation of those who break under the strain of war. The regular civilian activities of the Committee are, however, also described and a brief section of the report is devoted to the preparations that are being made to deal with the problems of the post-war period. Any one who wishes to secure a copy of the report can do so by writing to The National Committee for Mental Hygiene.

A sympathetic interpretation of what goes on in the mind of the soldier returning to the everyday civilian world after his sojourn in hell is given in a little booklet issued and distributed by the A and P Stores, under the title *Older Than God*. The booklet, which is by Bernard DeVoto, originally appeared as an article in *Woman's Day*, the A and P magazine. It is attractively printed and very simply written, in terms that call for no psychiatric or psychological background to be understood. It should be of interest not only to all workers with ex-service men, but to every one whose hopes and dreams center around the day when a soldier will be coming home. The A and P Stores are to be congratulated on the service they are rendering by placing such material as this in the hands of the wide public with which they come in contact. A copy of the booklet can be obtained by writing to Department No. 644, *Woman's Day*, 19 W. 44th St., New York 18, N. Y. Three cents, to cover cost of mailing, should be enclosed.

The psychological adjustments that a total war necessitates, and the attitudes with which people—both members of the armed forces and civilians—may react to them, are discussed in a 24-page booklet, *Understanding People in Wartime*, issued by the National Travelers Aid Association, of 425 Fourth Avenue, New York 16, N. Y. The booklet takes up also the psychological handling of war casualties, offering ten rules “useful as guidance in the proper and helpful approach to the sensitive and emotionally upset disabled soldier.”

The problems with which the church will be faced in meeting the needs of returning service men and women is the theme of a series of pamphlets under preparation by the Federal Council of Churches. *The Church and Returning Service Personnel* is the general title of the series. The first of these pamphlets, *Attitudes and Problems*, is already available. Single copies may be secured from the Federal Council of Churches, 297 Fourth Avenue, New York 10, N. Y., at a price of 10 cents. Ten or more copies are 8 cents each; one hundred or more, 7 cents; and one thousand or more, 6 cents each. All are postpaid.

The following publications have been listed for distribution by the Hogg Foundation for Mental Hygiene, The University of Texas, Austin, Texas: 1. *Teen Age Problems; What Recreation Can Do About It*, a 24-page pamphlet issued by the National Recreation Association. 2. *Social Protection Through Health and Happiness*, by Fred R. Kearney, a pamphlet containing practical suggestions for community workers. 3. *Juvenile Delinquency as Viewed by the Courts*, a leaflet prepared by Judge J. Harris Gardner. 4. *Preventing*

War Time Delinquency, by Lois Sayer. 5. *Children and the War*, by Daniel A. Prescott. 6. *Safeguarding the Family in War Time*. 7. *A Study of Community Attitudes Toward Mental Hygiene*, by Lucile Allen.

A bibliography on psychiatric and mental-hygiene aspects of civilian rehabilitation is now available. The material included is recent, covering the years 1942-44. Copies may be obtained from The National Committee for Mental Hygiene, Division on Rehabilitation, 525 East 68th Street, New York 21, New York.

The Child Study Association of America, of 221 West 57th Street, New York 19, N. Y., announces the publication of two new illustrated booklets for mothers of young children—*What Makes a Good Home* and *What Makes Good Habits—The Beginnings of Discipline*. Price: 15 cents each, 25 cents together.

Two excellent pamphlets on juvenile delinquency—*Understanding Juvenile Delinquency* and *Controlling Juvenile Delinquency*—have been issued by the U. S. Children's Bureau, of Washington, D. C.

A CORRECTION

The editors of MENTAL HYGIENE wish to express their regret for a mistake in the heading of the review of the book by Clifford R. Shaw and Henry D. McKay which appears on page 317, of the April issue of MENTAL HYGIENE. The title of the book under review there is *Juvenile Delinquency and Urban Areas*. Through an editorial error, however, it is given as *Juvenile Delinquents Grown Up*, the title of a book by Eleanor and Sheldon Glueck which was published in 1940 by the Commonwealth Fund, of New York. The publisher of *Juvenile Delinquency and Urban Areas* is, as stated in the heading of the review, the Chicago University Press.

CURRENT BIBLIOGRAPHY *

Compiled by

EVA R. HAWKINS

The National Health Library

Abel, Theodora M., Piotrowski, Z. A. and Stone, Gertrude. Responses of Negro and white morons to the Rorschach test. *American journal of mental deficiency*, 48:253-57, January 1944.

Abild, Ruth H. Money in his pocket. *Parents' magazine*, 19:39, '91-93, May 1944.

Abrahamsen, David, M.D. The dynamic connection between personality and crime and the detection of the potential criminal illustrated by different types of murder. *Journal of criminal psychopathology*, 5:481-88, January 1944.

Abse, W. Theory of the rationale of convulsion therapy. *British journal of medical psychology (London)*, 20: 33-50, 1944, Part 1.

Ackerly, S. Spafford, M.D. Is there an anxiety component to every complaint? *Southern medical journal*, 37:287-90, May 1944.

Adams, Olga. Will your child be ready for school? *National parent-teacher*, 38:7-9, April 1944.

The alcohol problem; a symposium. Religious education, 39:3-30, January-February 1944.
I. Views on the alcohol problem, by Students of the School of alcohol studies. II. The alcohol problem: formulations and attitudes, by E. M. Jellinek. III. Alcohol and public opinion, by Dwight Anderson. IV. Statistics of alcoholic mental disease, by Benjamin Malzberg.

Alexander, Franz, M.D. A world without psychic frustration. *American journal of sociology*, 49:465-69, March 1944.

Allen, Edward B., M.D. Emotional factors in alcoholism. *New York state journal of medicine*, 44:373-78, February 15, 1944.

Amdur, Meyer K., M.D. Psychiatry a century ago (in 1840). *American journal of psychiatry*, 100:18-28, April 1944.

American council on education. Commission on teacher education. Teachers for our times. Understanding the child, 13:17-19, April 1944.

Anderson, John E. Moving toward maturity. *National parent-teacher*, 38:10-12, April 1944.

Anderson, Victor V., M.D. Psychiatry in industry. *American journal of psychiatry*, 100:134-38, April 1944.

Arthur, Grace. An experience in examining an Indian twelfth-grade group with the Multiphasic personality inventory. *Mental hygiene*, 28: 243-50, April 1944.

Aschaffenburg, Gustav, M.D. The psychiatric aspect of testamentary capacity. *American journal of psychiatry*, 100:606-9, March 1944.

Avrunin, William. The volunteer in case work treatment. *Family*, 25: 137-42, June 1944.

Baker, Helen. Employee counseling. *Personnel journal*, 22:354-62, April 1944.

Balint, Alice. Identification. *International journal of psycho-analysis (London)*, 24:97-107, 1943, Pts. 3 and 4.
I. The conquest of the external world. II. The child and his educators.

Banay, Ralph S., M.D. Pathologic reaction to alcohol. *Quarterly journal of studies on alcohol*, 4:580-605, March 1944.

Banay, Ralph S., M.D. A psychiatrist looks at the zoot suit. *Probation*, *National probation association*, 22: 81-85, February 1944.

Barbato, Lewis, M.D. Psychiatric problems in military service. *Rocky Mountain medical journal*, 41:163-67, March 1944.

* This bibliography is uneritical and does not include articles of a technical or clinical nature.

Barrett, Joseph E., M.D. The rôle of occupational therapy in a mental hospital. *Virginia medical monthly*, 71:186-87, April 1944.

Barrett, William G., M.D. Psychologic arming for the air forces. *War medicine*, 5:142-45, March 1944.

Bathurst, M. E. Juvenile delinquency in Britain during the war. *Journal of criminal law and criminology*, 34: 291-302, January-February 1944.

Beals, Frank L. Wartime problems of children. *Hygeia*, 22:268-69, 296, 298, 300, April 1944.

Bean, Metta. Some plain talk by a social worker. *Mental health, Wisconsin society for mental hygiene*, 7:8-10, January-February 1944.

Beck, Samuel J. The Rorschach test in a case of character neurosis. *American journal of orthopsychiatry*, 14:230-36, April 1944.

Belgium, David. Stuttering. *Hygeia*, 22:346-47, 391, May 1944.

Berg, Charles. A case showing some implications of short treatment. *British journal of medical psychology (London)*, 20:1-19, 1944, Part I.

Berman, Jean and Berman, L. H. The signing out of tuberculosis patients. *Family*, 25:67-73, April 1944.

Blackman, Nathan, M.D. and Klebanoff, S. G. The rôle of rural socio-cultural factors in the functional psychoses. *Psychiatric quarterly*, 18:301-15, April 1944.

Bodman, Frank, M.D. Psychological development of the child. *Mother and child (London)*, 14:215-17, February 1944.

Bogen, David. Juvenile delinquency and economic trend. *American sociological review*, 9:178-84, April 1944.

Boggs, Marjorie H. The rôle of social work in the treatment of inebriates. *Quarterly journal of studies on alcohol*, 4:557-67, March 1944.

Bond, Earl D., M.D. Psychiatry in Philadelphia in 1844. *American journal of psychiatry*, 100:16-17, April 1944.

Bonner, Clarence A., M.D. Industrial nursing: The psychiatric approach. *American journal of nursing*, 44: 470-72, May 1944.

Bonte, Eleanor P. and Musgrave, Mary. Influences of war as evidenced in children's play. *Child development*, 14:179-200, December 1943.

Bossard, James H. S. Family problems in wartime. *Psychiatry*, 7: 65-72, February 1944.

Brierley, Marjorie. Theory, practice and public relations. *International journal of psycho-analysis (London)*, 24:119-25, 1943, Pts. 3 and 4.

Brill, A. A., M.D. Psychoanalytic fragments. *Psychoanalytic review*, 31:121-27, April 1944.

Brown, Robert W., M.D. Tuberculosis rate in Western state hospital. *Northwest medicine*, 43:116-17, April 1944.

Brown, Warren T., M.D. and Moore, Merrill, M.D. Soldiers who break down in battle: some predisposing factors. *Military surgeon*, 94:160-61, March 1944.

Brown, Warren T., M.D. and Moore, Merrill, M.D. Soldiers who break down: the family background and the past history. *Military surgeon*, 94:162-63, March 1944.

Brush exhibition reveals facts on feeble-mindedness. *Museum news, Cleveland health museum*, 5:2-3, April 1944.

Bunker, Henry A., M.D. Mother-murder in myth and legend; a psychoanalytic note. *Psychoanalytic quarterly*, 13:198-207, April 1944.

Burgum, Mildred. The fear of explosion. *American journal of orthopsychiatry*, 14:349-57, April 1944.

Cameron, Eugenia S., M.D. Community mental health programs. *Mental health, Wisconsin society for mental hygiene*, 7:10-12, January-February 1944.

Canadian teachers and administrators give their views on "discipline." *Understanding the child*, 12:18-19, January 1944.

Cantor, Nathaniel. Knowledge and skill in case work. *American journal of orthopsychiatry*, 14:325-29, April 1944.

Caprio, Frank S., M.D. Postwar planning in mental hygiene. *Medical record*, 157:93-95, February 1944.

The care of the mentally ill in the state of New York; report of the Moreland commission. *Mental hygiene news, New York state department of mental hygiene*, 14:1, 3, April 1944.

Cason, Hulsey. The prisoners personality scale: a method of penal research. *Journal of criminal psychopathology*, 5:495-520, January 1944.

Cheney, Clarence O., M.D. Dorothea Lynde Dix—servant of the Lord. *American journal of psychiatry*, 100: 61-68, April 1944.

Christensen, Erwin O. Freud on Leonardo da Vinci. *Psychoanalytic review*, 31:153-64, April 1944.

Clink, Stephen H. Prevention and treatment of juvenile delinquency. *Mental hygiene bulletin, Michigan*

society for mental hygiene, 3:1-3, 1943.

Colby, Mary R. Agreements used by child placing agencies. Child welfare league of America, Bulletin, 23: 4-7, 13-14, April 1944.

Cole, Stewart G. Intercultural education: an intellectual and emotional task. Understanding the child, 13: 12-13, April 1944.

Coleman, Jules V., M.D. Depression masked as malnutrition. Psychiatric quarterly, 18:233-39, April 1944.

Collier, K. G. The rôle of projection in the genesis of the super-ego. British journal of medical psychology (London), 20:96-99, 1944, Part I.

Cowin, Marion. Case studies: the story of Rudie. Understanding the child, 13:22-26, April 1944.

Craig, Le Roy N. Psychiatric nursing for navy hospital corpsmen. American journal of nursing, 44:459-60, May 1944.

Cranford, Victoria and Seliger, R. V., M.D. Alcohol psychopathology in a family constellation. Journal of criminal psychopathology, 5:571-84, January 1944.

Crofton, J. W., M. B. and Diggle, G., M.B. Confusional psychoses following sulphaguanidine therapy. Lancet (London), 246:367-68, March 18, 1944.

Cunningham, James M., M.D. Detention of the mentally-ill. Connecticut health bulletin, State department of health, 58:23-24, February 1944.

Curtis, Ethel L. Building toward academic readiness in mentally deficient children. American journal of mental deficiency, 48:183-87, October 1943.

Daly, C. D. The rôle of menstruation in human phylogeny and ontogeny. International journal of psycho-analysis (London), 24:151-70, 1943, Pts. 3 and 4.

Darlington, H. S. The fear of false teeth. Psychoanalytic review, 31: 181-94, April 1944.

Dashiell, Alice T. and Keeley, Mary. Day care, a review of organization and administration. Child welfare league of America, Bulletin, 23:1-3, April 1944.

Davidoff, Eugene, M.D. and Raffaele, Angelo, M.D. Electric shock therapy in involutional psychoses. Journal of nervous and mental disease, 99: 397-405, April 1944.

Davidoff, Eugene, M.D. and Noetzel, E. S. The function of the mental hygiene clinic during the war with special reference to juvenile delinquency. Journal of criminal psychopathology, 5:561-69, January 1944.

Davies, Stanley P. About face! to civilian life. Better times, Welfare council of New York City, 25:1-2, 12, March 31, 1944.

Davis, John E. Motivational values of periodic award days and play festivals for psychotic patients. Mental hygiene, 28:251-62, April 1944.

de Forest, Izette. Love and anger: the two activating forces in psychoanalytic therapy. Psychiatry, 7:15-29, February 1944.

Deibel, A. W. Nursing care of war neurosis cases. Hospital corps quarterly, 17:26-32, March 1944.

Democracy in our classroom by the fifth graders. Understanding the child, 12:8-9, January 1944.

Denny-Brown, Derek E., M.B. The clinical aspects of traumatic epilepsy. American journal of psychiatry, 100:585-92, March 1944.

DeProsopo, Chris J. Services of the specialist in guidance and placement of the mentally retarded. American journal of mental deficiency, 48: 299-301, January 1944.

The Detroit group project: a new enterprise of agency service and group psychological research. Mental hygiene bulletin, Michigan society for mental hygiene, 3:8-10, 1943.

Deutsch, Albert. Psychiatry as state medicine. American journal of psychiatry, 100:184-90, April 1944.

de Weerdt, Ole N. Psychology in wartime. III. Fearing can become a habit. Mental health, Wisconsin society for mental hygiene, 7:3-7, January-February 1944.

Diamond, Bernard L., M.D. and Schmale, H. T., M.D. The Mosaic test. I. An evaluation of its clinical application. American journal of orthopsychiatry, 14:237-50, April 1944.

Discipline: a social problem of worldwide scope. Understanding the child, 12:1-2, 26, January 1944.

Dorman, Olive E. Jobs for mental patients: the use of outside employment as a tool in rehabilitation is described by the psychiatric social worker of the Worcester state hospital in Massachusetts. Survey mid-monthly, 80:115-17, April 1944.

Dorsey, John M., M.D. Some considerations on psychic reality. International journal of psycho-analysis (London), 24:147-51, 1943, Pts. 3 and 4.

Douglas, Marcella E. Some concrete contributions to occupational education in the academic classroom. *American journal of mental deficiency*, 48:288-91, January 1944.

Douglas-Wilson, Ian, M.D. Somatic manifestations of psychoneurosis. *British medical journal* (London), p. 413-15, March 25, 1944.

Draper, George, M.D. The concept of organic unity and psychosomatic medicine. *Journal of the American medical association*, 124:767-71, March 18, 1944.

Dunbar, Flanders, M.D. Effect of the mother's emotional attitude on the infant. *Psychosomatic medicine*, 6: 156-59, April 1944.

Dunham, H. Warren. The social personality of the catatonic-schizophrenic. *American journal of sociology*, 49: 508-18, May 1944.

Dunton, William R., Jr., M.D. The American journal of psychiatry (formerly the American journal of insanity) — 1844-1944. *American journal of psychiatry*, 100:45-60, April 1944.

Dunton, William R., Jr., M.D. The second half-century of the journal. *American journal of psychiatry*, 100: 41-44, April 1944.

Duvall, Evelyn M. and Neisser, E. G. Doing without dad. *National parent-teacher*, 38:7-9, May 1944.

Dybwid, Gunnar. Child welfare services in Michigan. *Mental hygiene bulletin*, Michigan society for mental hygiene, 3:3-5, 1943.

Ebaugh, Franklin G., M.D. The history of psychiatric education in the United States from 1844 to 1944. *American journal of psychiatry*, 100: 151-60, April 1944.

Ehrenwald, H. J. Telepathy in the psychoanalytic situation. *British journal of medical psychology* (London), 20:51-62, 1944, Part I.

Eighth service command postgraduate medical education program. Neuropsychiatric case report number 2. *Psychosomatic medicine*, 6:165-69, April 1944.

Einbinder, Zvée. The psychiatric hospital sees social service as a basic need. *Hospitals*, 18:59-63, March 1944.

Eisendorfer, Arnold, M.D. Clinical significance of extramural psychiatry in the army. *War medicine*, 5:146-49, March 1944.

Erickson, Milton H., M.D. A teaching program for commissioned reserve medical officers. *Diseases of the nervous system*, 5:112-15, April 1944.

Etz, Elizabeth. Pre-academic activities to challenge the mentally deficient child from five to eight years of mental age. *American journal of mental deficiency* 48:179-82, October 1943.

Evans, W. N. Notes on the conversion of John Bunyan: a study in English Puritanism. *International journal of psycho-analysis* (London), 24:176-85, 1943, Pts. 3 and 4.

Eysenck, H. J. The effect of incentives on neurotics and the variability of neurotics as compared with normals. *British journal of medical psychology* (London), 20:100-103, 1944, Part I.

Faegre, Marion L. You and your child's friends. *Parents' magazine*, 19:22-23, 117-19, April 1944.

Farr, Clifford B., M.D. Benjamin Rush and American psychiatry. *American journal of psychiatry*, 100:3-15, April 1944.

Fenichel, Otto. Psychoanalytic remarks on Fromm's book "Escape from freedom." *Psychoanalytic review*, 31:133-52, April 1944.

Fetterman, Joseph L., M.D. A note on rehabilitation: work as therapy. *Ohio state medical journal*, 40:117-22, February 1944.

Finesinger, Jacob E., M.D. The effect of pleasant and unpleasant ideas on the respiratory patterns (spirogram) in psychoneurotic patients. *American journal of psychiatry*, 100: 659-67, March 1944.

Finesinger, Jacob E., M.D. The needs of youth: the physiological and psychological factors in adolescent behavior. *Psychiatry*, 7:45-57, February 1944.

Fisher, V. E. Psychic shock treatment for early schizophrenia. *American journal of orthopsychiatry*, 14: 358-67, April 1944.

Fitzsimmons, Laura. Report of a survey of nursing in mental hospitals in the U. S. and Ontario, Canada. *American journal of psychiatry*, 100: 623-27, March 1944.

Fodor, Nandor. A personal analytic approach to the problem of the Holy Name. *Psychoanalytic review*, 31:165-80, April 1944.

Folks, Homer. Dawson commission reports on mental hygiene department. *S.C.A.A. news*, State charities aid association, 34:1-2, April 1944.

Foxe, Arthur N., M.D. Psychopathic behavior. *American journal of orthopsychiatry*, 14:308-12, April 1944.

MENTAL HYGIENE

Frank, Lawrence K. Wasted resources in childhood and youth. Understanding the child, 13:3-5, April 1944.

Freedman, Harry L., M.D. Mental hygiene first aid for precombat casualties. Mental hygiene, 28:186-213, April 1944.

Fries, Margaret E., M.D. Psychosomatic relationships between mother and infant. Psychosomatic medicine, 6:159-62, April 1944.

Frosch, John, M.D. The psychiatric patient in a wartime community. American journal of orthopsychiatry, 14:321-24, April 1944.

Frosch, John, M.D. Psychodynamics in a civilian war neurosis. Psychoanalytic quarterly, 13:186-97, April 1944.

Fry, Clements C., M.D. and Rostow, E. G. The view from the chair: a review of the presidential addresses. American journal of psychiatry, 100:69-79, April 1944.

Fultz, A. F. Music as a modality of occupational therapy. War medicine, 5:139-41, March 1944.

Giberson, Lydia G., M.D. Mental health in industry. Industrial medicine, 13:276, 278, 280, March 1944.

Giberson, Lydia G., M.D. The older worker. Canadian medical association journal, 50:422-26, May 1944.

Gitelson, Maxwell, M.D. Intellectuality in the defense transference. Psychiatry, 7:73-86, February 1944.

Goitein, P. Lionel, M.D. The diary of a self slasher. Journal of criminal psychopathology, 5:521-40, January 1944.

Goitein, P. Lionel, M.D. and Kutash, S. B. Field forces of the ego and their measure by projective technique. Journal of criminal psychopathology, 5:541-60, January 1944.

Goldfarb, William. The effects of early institutional care on adolescent personality (graphic Rorschach data). Child development, 14:213-23, December 1943.

Gordon, H. L. Adoption application form. Child welfare league of America, Bulletin, 23:10-11, April 1944.

Gordon, Keith, M.D. Effort syndrome. (Editorial.) Canadian medical association journal, 50:362-63, April 1944.

Gottfried, Leanore V. Medical social work in the war relocation program. Family, 25:108-13, May 1944.

Graham, William J. F. Corpsmen get psychiatric training. Trained nurse and hospital review, 112: 189-90, March 1944.

Gralnick, Alexander, M.D. Psychotherapeutic and interpersonal aspects of insulin treatment. Psychiatric quarterly, 18:179-96, April 1944.

Greco, Marshall C. and Wright, J. C. The correctional institution in the etiology of chronic homosexuality. American journal of orthopsychiatry, 14:295-307, April 1944.

Green, Eugene W., M.D. and Johnson, L. G., M.D. Homosexuality. Journal of criminal psychopathology, 5:467-80, January 1944.

Greenacre, Phyllis, M.D. Infant reactions to restraint; problems in the fate of infantile aggression. American journal of orthopsychiatry, 14:204-18, April 1944.

Greenson, Ralph R. On genuine epilepsy. Psychoanalytic quarterly, 13:139-59, April 1944.

Gregg, Alan, M.D. Narrative for a specialist. American journal of psychiatry, 100:191-94, April 1944.

Grinker, Roy R., M.D. and Spiegel, J. P., M.D. Brief psychotherapy in war neuroses. Psychosomatic medicine, 6:123-31, April 1944.

Grossman, Sol S., M.D. The psychiatric screening process for selectees; some observations made at U. S. armed forces induction station, Kalamazoo, Michigan. Mental hygiene, 28:224-42, April 1944.

Grotjahn, Martin, M.D. Psychoanalytic contributions to psychosomatic medicine. A bibliography. Psychosomatic medicine, 6:169-75, April 1944.

Haskell, Robert H., M.D. Mental deficiency over a hundred years: a brief historical sketch of trends in this field. American journal of psychiatry, 100:107-18, April 1944.

Haugaard, William E. "Musts" for the care of the mentally ill. Modern hospital, 62:64, March 1944.

Heath, Robert G., M.D. and Powdermaker, Florence, M.D. The use of ergotamine tartrate as a remedy for "battle reaction." Journal of the American medical association, 125:111-13, May 13, 1944.

Heilbrunn, Gert, M.D. The present status of psychiatric therapy in state hospitals. Illinois psychiatric journal, 3:9-22, December 1943.

Henderson, J. L., M.D. and Moore, Merrill, M.D. The psychoneuroses of war. New England journal of medicine, 230:273-78, March 9, 1944.

Henschke, Erna. Case work with families in wartime. Child welfare league of America, Bulletin, 23:1-3, 8, February 1944.

Hewitt, Charles C. A personality study of alcohol addiction. Quarterly journal of studies on alcohol, 4:368-86, December 1943.

Hill, Joel M., M.D. Nervous reactions in naval war time personnel. Northwest medicine, 43:114-15, April 1944.

Himwich, Harold E., M.D. and Fazekas, J. F. Brain metabolism and mental deficiency. American journal of mental deficiency, 48:137-41, October 1943.

Hincks, Clarence M., M.D. What of the future for American psychiatry? American journal of psychiatry, 100:195-98, April 1944.

Hinsie, Leland E., M.D. Societal evolution and psychiatry. American journal of psychiatry, 100:174-83, April 1944.

Hollitscher, Walter. On the concepts of psychological health and illness. International journal of psychopathology (London), 24:125-40, 1943. Pts. 3 and 4.

Holway, A. R. How can we improve discipline in the classroom? Understanding the child, 12:3-7, January 1944.

Honsberger, J. D. Family case work and orthopsychiatry. American journal of orthopsychiatry, 14:330-37, April 1944.

Houwink, Eda. The endowment of the supervisor. Family, 25:57-60, April 1944.

Hunt, William A., Wittson, C. L., M.D. and Jackson, M.M. Selection of naval personnel with special reference to mental deficiency. American journal of mental deficiency, 48:245-52, January 1944.

Hutchings, Richard H., M.D. The first four editors. American journal of psychiatry, 100:29-40, April 1944.

Amariah Brigham, founder and first editor of the American journal of insanity. T. Romeyn Beck—editor 1849-1854. John P. Gray—editor 1854-1886. G. Alder Blumer—editor 1886-1894.

Hutchinson, Dorothy. The request for placement has meaning. Family, 25:128-32, June 1944.

Jelliffe, Smith E., M.D. Two morphine color dreams; with a note on the etiology of the opium habit. Psychoanalytic review, 31:128-32, April 1944.

Jellinek, Elvin M. The alcohol problem: formulations and attitudes. Quarterly journal of studies on alcohol, 4:446-61, December 1943.

Jellinek, Elvin M. Alcohol research—theoretical and practical. Public health nursing, 36:223-29, May 1944. (To be continued).

Jellinek, Elvin M. Establishment of diagnostic and guidance clinics for inebriates in Connecticut (Yale plan clinics). Quarterly journal of studies on alcohol, 4:496-507, December 1943.

Jenkins, Richard L., M.D. The responsibility of the local community in child guidance. Welfare bulletin, Illinois state department of public welfare, 35:21-23, March 1944.

Jensen, Reynold A., M.D. Children's psychosomatic complaints and the war. Journal-Lancet, 64:161-63, May 1944.

Johnson, Adelaide M., M.D., and Fishback, Dora, M.D. Analysis of a disturbed adolescent girl and collaborative psychiatric treatment of the mother. American journal of orthopsychiatry, 14:195-203, April 1944.

Juvenile delinquency [symposium]. Survey midmonthly, 80:69-95, 105-6, March 1944.

The challenge to all of us, by A. H. MacCormick. How to begin, by Bradley Buell. New rôle of the police, by Eliot Ness. Four grown-ups and a child, by Kathryn Close. Good ideas at work—A look at ten communities, by Genevieve Gabow. What do we know about delinquency? by Sheldon and Eleanor Glueck—Federal and state action, by K. F. Lenroot.

Kallmann, Franz J., M.D., Schoenfield, W. A. and Barrera, S. E., M.D. The genetic aspects of primary eunuchoidism. American journal of mental deficiency, 48:203-36, January 1944.

Kanner, Leo, M.D. The origins and growth of child psychiatry. American journal of psychiatry, 100:139-43, April 1944.

Kelly, Elizabeth M. Preparation of the mentally handicapped child for the post-war world. Journal of exceptional children, 10:146-50, March 1944.

Kerschbaumer, L., M.D. Bird language in schizophrenia. Psychoanalytic review, 31:195-96, April 1944.

Kirkpatrick, Milton E., M.D. What college women know about social work. American journal of orthopsychiatry, 14:338-44, April 1944.

Klopfen, Bruno. Is inclination to mental disease within a population group a "racial" factor? A statistical study of the frequency of five major mental diseases among Italian, Irish,

and German immigrants and their descendants in the states of New York and Massachusetts. *Psychiatric quarterly*, 18:240-72, April 1944.

Komora, Paul O. Dr. Horatio M. Pollock retires from the New York state department of mental hygiene. *American journal of mental deficiency*, 48:318-20, January 1944.

Kotler, Julia. Contribution of a Red Cross unit to the rehabilitation of a military patient. *Family*, 25:102-7, May 1944.

Kraines, Samuel H., M.D. Prophylactic psychiatry in the army. *Bulletin, U. S. Army medical department*, p. 77-81, No. 75, April 1944.

Kratz, John A. New horizons in rehabilitation. *Federal probation*, 8: 34-36, January-March 1944.

Kriegman, George, M.D. and Hilgard, J. R., M.D. Intelligence level and psychotherapy with problem children. *American journal of orthopsychiatry*, 14:251-65, April 1944.

Kubie, Lawrence S., M.D. and Margolin, Sydney, M.D. The process of hypnotism and the nature of the hypnotic state. *American journal of psychiatry*, 100:611-22, March 1944.

Kugelmass, Isaac N., M.D. The nutritional basis of nervous and mental disorders in children. *American journal of mental deficiency*, 48:142-52, October 1943.

Kuhlmann, Frieda M. Placement resulting from psychosexual disturbances in a mother-son relationship. *Family*, 25:143-51, June 1944.

Kvaraceus, William C. Delinquency—a by-product of the school? *School and society*, 59:350-51, May 13, 1944.

Lamm, Stanley S., M.D. Asphyxia as a cause of mental deficiency: suggestions as to prevention. *American journal of mental deficiency*, 48:131-36, October 1943.

Landuyt, Meta L. Case work in a public assistance agency. *Family*, 25:43-50, April 1944.

Lane, Ruth R. Suggestions for handling young stutterers. *Elementary school journal*, 44:416-19, March 1944.

Lantos, Barbara. Work and the instincts. *International journal of psycho-analysis* (London), 24:114-19, 1943, Pts. 3 and 4.

Lawton, George. Mental decline and its retardation. *Scientific monthly*, 58:313-17, April 1944.

Lazarsfeld, Sofia. Did Oedipus have an oedipus complex? *American journal of orthopsychiatry*, 14:226-29, April 1944.

Lehtinen, Laura E. and Strauss, A. A., M.D. A new approach in educational methods for brain-crippled deficient children. *American journal of mental deficiency*, 48:283-87, January 1944.

Leitch, Alexander. A survey of reformative influences in Borstal training. A socio-psychological study. *British journal of medical psychology* (London), 20:77-95, 1944, Part I.

Levine, Albert J. Psychology for parents. *Journal of criminal psychopathology*, 5:585-96, January 1944.

Liber, Benzion, M.D. Population and the war. *Medical record*, 157:95-97, February 1944.

Linder, Robert M. A formulation of psychopathic personality. *Psychiatry*, 7:59-63, February 1944.

Liss, Edward, M.D. Examination anxiety. *American journal of orthopsychiatry*, 14:345-48, April 1944.

Lottier, Stuart. Predicting criminal behavior. *Federal probation*, 7:8-12, October-December 1943.

McAlpine, Paul T., M.D. Hysterical visual defects. *War medicine*, 5: 129-32, March 1944.

McCartney, James L., M.D. White men in the tropics. *Diseases of the nervous system*, 5:133-38, May 1944.

McGinnis, John M. Some aspects of the psychology of the offender. *Federal probation*, 8:20-23, January-March 1944.

McPeek, Francis W. Youth, alcohol and delinquency. *Quarterly journal of studies on alcohol*, 4:568-79, March 1944.

Malzberg, Benjamin. The expectation of an alcoholic mental disorder in New York state, 1920, 1930, and 1940. *Quarterly journal of studies on alcohol*, 4:523-34, March 1944.

Mann, E. B. Case studies: Pete's ship comes home. *Understanding the child*, 12:20-26, January 1944.

Martens, Elise H. When a child learns slowly. *National parent-teacher*, 38:20-22, May 1944.

Mason, Irwin, M.D. An index of the severity of criminalism or psychopathy. *Bulletin, U. S. Army medical department*, p. 110-14, No. 75, April 1944.

"The Massachusetts plan." A method for obtaining socio-medical histories on selectees. Monthly bulletin, Massachusetts society for mental hygiene, p. 1-4, December 1943.

Masserman, Jules H., M.D. The dynamic psychology of war-time communications and morale. *Diseases*

of the nervous system, 5:101-11, April 1944.

Maxwell, G. L. After the war, what about youth? *National parent-teacher*, 38:4-6, May 1944.

Mayer, William, M.D. Additional notes on the unusual course in certain cases of migraine. *Psychiatric quarterly*, 18:298-300, April 1944.

Mead, Margaret. Preparing children for a world society. *Childhood education*, 20:345-48, April 1944.

The medical survey program. (Editorial.) *Mental hygiene*, 28:177-78, April 1944.

Menger, Clara. Organizing a child guidance service in a community. *Welfare bulletin, Illinois state department of public welfare*, 35:12-13, 16, February 1944.

Menninger, Karl A., M.D. Present trends in psychoanalytic theory and practice. *Bulletin of the Menninger clinic*, 8:14-17, January 1944.

Menninger, Roy W. The history of psychiatry. *Diseases of the nervous system*, 5:52-55, February 1944.

Menninger, William C., M.D. Opportunities for treatment of neuro-psychiatric patients. *Bulletin, U. S. Army medical department*, p. 90-98, No. 74, March 1944.

Meyer, Adolf, M.D. The rise to the person and the concept of wholes or integrates. *American journal of psychiatry*, 100:100-6, April 1944.

Mitchell, Margaret. A delinquent adolescent. *Family*, 25:83-88, May 1944.

Montagu, Montague F. A. The physical anthropology of the American Negro. *Psychiatry*, 7:31-44, February 1944.

Murray, John M., M.D. Psychiatric aspects of aviation medicine. *Psychiatry*, 7:1-7, February 1944.

Murray, John M., M.D. Some special aspects of psychotherapy in the army air forces. *Psychosomatic medicine*, 6:119-22, April 1944.

Myerson, Abraham, M.D. Some trends of psychiatry. *American journal of psychiatry*, 100:161-73, April 1944.

Nau, William C. Poor health—a persistent problem in supervision. *Federal probation*, 8:29-33, January-March 1944.

Naumburg, Margaret. The drawings of an adolescent girl suffering from conversion hysteria with amnesia. *Psychiatric quarterly*, 18:197-224, April 1944.

Nowrey, Joseph E., M.D. A tuberculosis survey in an institution. *American journal of mental deficiency*, 48:237-44, January 1944.

Nussbaum, Kurt, M.D. Correlation of some psychiatric problems encountered at induction centers and in army hospitals. *Psychiatric quarterly*, 18:225-32, April 1944.

Oberndorf, Clarence P., M.D. Psychic determinism in Holmes and Freud. *Mental hygiene*, 28:289-99, April 1944.

Oberndorf, Clarence P., M.D. Results of psycho-analytic therapy. *International journal of psycho-analysis (London)*, 24:107-14, 1943, Pts. 3 and 4.

Ojemann, Ralph H. Preparation for parenthood. *National parent-teacher*, 38:32-33, May 1944.

O'Neill, Will. "The \$35,000 question." *Hygeia*, 22:258, 282-83, April 1944.

Osgood, C. W., M.D. Changes in institutional psychiatric practice in the past decade. (Observations from a private sanitarium.) *Wisconsin medical journal*, 43:532-36, May 1944.

Overstreet, Harry A. We needn't lose touch with our children. *National parent-teacher*, 38:10-12, May 1944.

Palmer, Harold D., M.D. The organic and physiologic factors in mental defect. Part II. Diseases of the nervous system, 5:37-51, February 1944.

Patterson, R. M. Organization of a residence unit for pre-academic training of mentally deficient children. *American journal of mental deficiency*, 48:174-78, October 1943.

Paull, Dorothy. The rejectee is a person, not a case. *Mental hygiene news, Wisconsin society for mental hygiene*, 6:1-5, November-December 1943.

Pennington, L. A. and Mearin, R. J., M.D. The frequency and significance of a movement mannerism for the military psychiatrist. *American journal of psychiatry*, 100:628-32, March 1944.

Piper, Ellsmer L., M.D. The pediatrician's rôle in speech correction. *Pennsylvania medical journal*, 47:483-88, February 1944.

Pollock, Horatio M. and Wiley, E. D. A contribution to the history of psychiatric expert testimony. *American journal of psychiatry*, 100:119-33, April 1944.

Pratt, John. Notes on commercial movie technique. *International journal of psycho-analysis (London)*, 24:185-88, 1943, Pts. 3 and 4.

Pre-induction screening of registrants. *Mental hygiene news, Wisconsin so-*

ciety for mental hygiene, 6:12-13, November-December 1943.

Preston, George H., M.D. President's address. American journal of orthopsychiatry, 14:191-94, April 1944.

Preston, Ralph C. Alternatives for the persecuted child. Mental hygiene, 28:273-78, April 1944.

Price, Jerry C., M.D. and Putnam, T. J., M.D. The effect of intrafamily discord on the prognosis of epilepsy. American journal of psychiatry, 100: 593-98, March 1944.

Prout, Curtis T., M.D. Psychiatric reactions to the war as seen in civilians and soldiers referred to a mental hospital. Journal of nervous and mental disease, 99:389-96, April 1944.

Psychological problems of later maturity; round table. American journal of orthopsychiatry, 14:266-84, April 1944.

Contents: Introductory statement, by George Lawton. Measuring mental efficiency in senescence, by J. G. Gilbert. Measuring mental competency in the aging, by M. A. Seidenfeld. Old age from the standpoint of the traffic situation, by L. S. Selling, M.D. Age and highway accidents, by H. R. de Silva. Rehabilitation applied to older persons, by I. L. Peters. Concluding remarks, by George Lawton.

Psychology in wartime. II. Fear and morale. Mental hygiene news, Wisconsin society for mental hygiene, 6:7-11, November-December 1943.

Quance, F. M. "Not the intellect, but the heart"—today and yesterday. Understanding the child, 12:10-12, January 1944.

Quinn, Julia P. The client with severe personality disturbances. Family, 25:88-95, May 1944.

Quint, Mary D. The mental-hospital library. Mental hygiene, 28:263-72, April 1944.

Religion and psychiatry. New England journal of medicine, 230:334-36, March 16, 1944.

Rennie, Thomas A. C., M.D. A plan for the organization of psychiatric rehabilitation clinics. Mental hygiene, 28:214-23, April 1944.

Rheingold, Harriet L. Behavior problems of the emotionally dependent child. Welfare bulletin, Illinois state department of public welfare, 35: 19-21, January 1944.

Ricker, M. Belle. The "best way" in classroom discipline. Understanding the child, 13:8-11, April 1944.

Riemer, Morris D., M.D. The psychology of ideas of unreality with emphasis on feelings of strangeness. Psychiatrische quarterly, 18:316-26, April 1944.

Riezler, Kurt. The social psychology of fear. American journal of sociology, 49:489-98, May 1944.

Robins, Sol A., M.D. Safeguards for the mentally ill. Modern hospital, 62:82-83, May 1944.

Roe, Anne. Intellectual functions in alcoholic psychoses. Quarterly journal of studies on alcohol, 4:517-22, March 1944.

Róheim, Géza. War, crime and the covenant. Part III. Crime in primitive society. Journal of criminal psychopathology, 5:597-626, January 1944. (To be concluded.)

Rollin, Henry R. Trade training failures in the W.A.A.F. Factors in predisposition and precipitation. British journal of medical psychology (London), 20:63-76, 1944, Part I.

Rome, Howard P., M.D. The rôle of sedation in military medicine. United States naval medical bulletin, 42:525-34, March 1944.

Rosanoff, William R., M.D. A note on the incidence of rheumatic heart disease among criminal psychopaths. American journal of psychiatry, 100: 708, March 1944.

Ross, Hugh G., M.D. Human behaviour and its relation to industry. Canadian medical association journal, 50:202-8, March 1944.

Rubin, Herbert E., M.D. Identical twins with psychosis. Kentucky medical journal, 42:115-18, April 1944.

Ruggles, Arthur H., M.D. Clifford Beers and American psychiatry. American journal of psychiatry, 100: 98-99, April 1944.

Russell, William L., M.D. From asylum to hospital—A transition period. American journal of psychiatry, 100: 87-97, April 1944.

Ryan, Calvin T. Speech is important. Hygeia, 22:306-8, April 1944.

Ryan, Will C. History of mental hygiene in the schools. American journal of psychiatry, 100:144-43, April 1944.

Sandy, William C., M.D. Psychiatry belongs in the program of cadet nurse training. Modern hospital, 62: 79-80, April 1944.

Sarkar, Sarasi L. A study of the psychology of sexual abstinence from the dreams of an ascetic. International journal of psycho-analysis

(London), 24: 170-75, 1943, Pts. 3 and 4.

Scarlett, Earle P., M.B. and Houghtling, W. J., M.D. Psychosis in hypoparathyroidism. Canadian medical association journal, 50:351-52, April 1944.

Schmitz, Marian E. The use of volunteers in case work. Family, 25: 50-57, April 1944.

Schneck, Jerome M. The problem of sterilization of the mentally unfit. Medical record, 157:223-27, April 1944.

A school administrators' program for delinquency prevention. Understanding the child, 13:20-21, April 1944.

Schwab, Robert S., M.D., Finesinger, J. E., M.D. and Brazier, M.A.B. Psychoneuroses precipitated by combat. United States naval medical bulletin, 42:535-44, March 1944.

Self emasculation. Journal of criminal psychopathology, 5:489-94, January 1944.

Seliger, Robert V. M.D. and Cranford, Victoria. The rôle of psychiatry in alcoholism. Virginia medical monthly, 71:191-98, April 1944.

Sicher, Lydia, M.D. War neuroses. Medical Woman's journal, 51:17-24, March 1944.

Silverman, Anne R. Case work with day nursery clients. Family, 25: 95-102, May 1944.

Silverman, Daniel, M.D. The electroencephalograph and therapy of criminal psychopaths. Journal of criminal psychopathology, 5:439-66, January 1944.

Silverman, Daniel, M.D. Electroencephalography in the army general hospital. War medicine, 5:163-68, March 1944.

Simmel, Ernst. Self-preservation and the death instinct. Psychoanalytic quarterly, 13:160-85, April 1944.

Skottowe, Ian, M.D. Psychological medicine: current methods of treatment. Lancet (London), 246:329-32, March 11, 1944.

Smith, Austin E., M.D. The beaten child. Hygeia, 22:386, 388, May 1944.

Sonenthal, Israel R., M.D. Malingering in nurses with hysteria. Illinois medical journal, 85:17-21, January 1944.

Spiller, Mary S. In the name of—discipline! Understanding the child, 13:6-7, April 1944.

Sterba, Richard, M.D. The significance of a missed diagnosis. Bulletin of the Menninger clinic, 8: 18-22, January 1944.

Stern, Edward S. The psychopathology of manic-depressive disorder and involutional melancholia. British journal of medical psychology (London), 20:20-32, 1944, Part I.

Stevenson, George S., M.D. The development of extra-mural psychiatry in the United States. American journal of psychiatry, 100:147-50, April 1944.

Stevenson, Iris and Strauss, A. A., M.D. The effects of an enriched vitamin B₂ (Riboflavin) diet on a group of mentally defective children with retardation in physical growth. American journal of mental deficiency, 48:153-56, October 1943.

Strauss, Alfred A., M.D. Ways of thinking in brain-crippled deficient children. American journal of psychiatry, 100:639-47, March 1944.

Strauss, Hans, M.D. The effect of mental activity on the incidence of seizures and the electroencephalographic pattern in some epileptics. Psychosomatic medicine, 6:141-45, April 1944.

Strecker, Edward A., M.D. The leaven of psychiatry in war and in peace: the president's message. American journal of psychiatry, 100:1-2, April 1944.

Strecker, Edward A., M.D. War neuroses. Military surgeon, 94:196-98, April 1944.

Sutherland, Robert L. "The Hogg foundation reports." Understanding the child, 13:14-16, April 1944.

Szurek, Stanislaus A., M.D. Child therapy procedures. Psychiatry, 7: 9-14, February 1944.

A ten-year program for the expansion of state institutions in Michigan. American journal of mental deficiency, 48:320-24, January 1944.

Thorne, Frederick C., M.D. Hysterical manifestations in mental defectives. American journal of mental deficiency, 48:278-82, January 1944.

Thorne, Frederick C., M.D. The incidence of nocturnal enuresis after age five. American journal of psychiatry, 100:686-89, March 1944.

Tooth, Geoffrey, M.B. Nervous breakdown in the navy: domestic difficulties as a causal factor. British medical journal (London), p. 358-60, March 11, 1944.

Tucker, Beverly R., M.D. Silas Weir Mitchell, 1829-1914: father of neurology and mentor of psychiatry in America. American journal of psychiatry, 100:80-86, April 1944.

U. S. Surgeon general's office. The division neuropsychiatrist. Bulletin,

U. S. Army medical department, p. 29-34, No. 74, March 1944.

Victor, Jules, Jr., M.D. Headaches—tension type. United States naval medical bulletin, 42:890-91, April 1944.

Voelker, Charles H. A preliminary investigation for a normative study of fluency. American journal of orthopsychiatry, 14:285-94, April 1944.

Wadsworth, Morton L., M.D. Persistent enuresis in adults. American journal of orthopsychiatry, 14:313-20, April 1944.

Waelder, Robert. Present trends in psychoanalytic theory and practice. Bulletin of the Menninger clinic, 8:9-13, January 1944.

Wagley, Perry V., M.D. The army rehabilitates military offenders. Federal probation, 8:14-19, January-March 1944.

Wagley, Perry V., M.D. Some criminologic implications of the returning soldier. Journal of criminal law and criminology, 34:311-14, January February 1944.

Wagner, Margaret W. Mental hazards in old age. Family, 25:132-37, June 1944.

Waldman, Marian. Chemical nurse: amytal—rehabilitator of shell shock victims—holds out hope as doorway to cure of neurosis. Health, Health league of Canada (Toronto), 11:9, 20, 30, Winter 1943-44.

Wallenberg, Marianne S., M.D. The influence of the draft on the formation of psychoses in women. Illinois medical journal, 85:25-29, January 1944.

Wallenberg, Marianne S., M.D. On the psychological effect of convulsive shock treatment. Illinois psychiatric journal, 3:23-25, December 1943.

Weidenrich, Marion. Function as a psychological concept: a dissenting opinion. Family, 25:60-66, April 1944.

What authorities say about "discipline" and "punishment." Understanding the child, 12:13-17, January 1944.

Whitney, Katherine M. A state hospital school for epileptic children. 1. The school and its problems. Journal of exceptional children, 10: 173-79, April 1944.

Whittman, Milton. Case work in a military setting. Family, 25:123-27, June 1944.

Wickman, Katharine M. and Langford, W. S., M.D. The parent in the children's psychiatric clinic. Ameri-can journal of orthopsychiatry, 14: 219-25, April 1944.

Wight, Frederick. Picasso and the unconscious. Psychoanalytic quarterly, 13:208-16, April 1944.

Williams, Herbert D. Integration of a training-school program with case-work service for individual children. Mental hygiene, 28:279-88, April 1944.

Williams, Tom A., M.D. Adequate treatment of psychoneuroses. Medi-cal record, 157:221-23, April 1944.

Williams, Vernon P., M.D. Psychiatry. New England journal of medicine, 230:382-85, March 30, 1944.

Winslow, C.-E. A. Clifford Whittingham Beers. Mental hygiene, 28:179-85, April 1944.

Wisdom, J. O. Determinism and psy-cho-analysis. International journal of psycho-analysis (London), 24: 140-47, 1943, Pts. 3 and 4.

Wishart, John H., M.D. and Lobb, Lois G., M.D. Personality problems in the first aid unit. Industrial med-icine, 13:243-45, March 1944.

Witmer, H. L. A theoretical basis for foreign relief and rehabilitation operations. Smith college studies in social work, 14:273-310, March 1944.

Wolberg, Lewis R., M.D. Phallic ele-ments in primitive, ancient and modern thinking. Psychiatric quar-terly, 18:278-97, April 1944.

Woodward, Luther E. A challenge to social work—the medical survey program of selective service. Com-pass, American association of social workers, 25:7-10, January 1944.

Wyckoff, Chauncey W., M.D. Emo-tional development of young chil-dren. Hygeia, 22:350-51, 380, 382-85, May 1944.

Yellowles, Henry, M.D. Mental strain in war time. Journal of the Royal institute of public health and hygiene (London), 7:37-47, February 1944.

Yerbury, Edgar C., M.D. and Newell, Nancy. Genetic and environmental factors in psychoses of children. American journal of psychiatry, 100: 599-605, March 1944.

Young, Imogene S. and Schuyler, Dorothea. Psychiatric social work in this war. Diseases of the nervous system, 5:118-21, April 1944.

Zeigler, Lloyd H., M.D. One big job before us is the rehabilitation of our psychiatric casualties. Modern hospital, 62:67-68, March 1944.

Zilboorg, Gregory, M.D. Present trends in psychoanalytic theory and prac-tice. Bulletin of the Menninger clinic, 8:3-8, January 1944.